HOSPITAL ABSTRACTS

A MONTHLY SURVEY OF WORLD LITERATURE

PREPARED BY THE DEPARTMENT OF HEALTH

AND SOCIAL SECURITY

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CONTENTS

	page
Hospitals in general	321
Hospitals in Great Britain	321
Hospitals in other countries	322
Planning, design and construction	323
Building: tendering, etc.	323
Construction methods and building materials	324
Hospital design	324
Design of individual general hospitals	324
Design of special departments	325
Design of special hospitals or units	326
Wards and patients' rooms	327
Engineering services	327
Electrical installations and equipment	327
Artificial lighting	328
Communication systems	328
Ventilation and air-conditioning	328
Insulation against sound and temperature	329
Maintenance of buildings and equipment	329
Sanitary equipment and fittings	329
Equipment, fittings, furniture	330
Beds, cots, etc.	330
Equipment generally	330
Electronic equipment	331
Staff generally	331
Recruitment	331
Salaries and superannuation	331
Staff management	332
Staff training	332
Staff welfare	332
Special classes of staff	333
Medical staff	333
Nursing staff	333
Other professional and technical staff	336
Ancillary staff	336
Organization and administration	336
Economics of hospital management	338
Running costs	339
Bed occupancy, economic use of beds	340
Appointment systems, waiting lists	340
Office management and methods	340
Data processing	341
Organization and methods, work study	341
Medical records	342
Hospital statistics	342
Hospital accreditation and similar schemes	342
Finance and accounting	342
Finance	343
Supplies and stores	344
Purchasing	344
Economic use of supplies, disposables	344
Catering, dietetics, kitchens	344
Hospital catering	344
Dietetics in the hospital	344
Hospital domestic management	345
Hygiene in the hospital	345
Hospital infections	346
Sources of infection	347
Prevention and control	348
Hygiene in the operating theatre	349
Air hygiene	349
Disposal of waste	349
Safety measures	349
Electrical accidents	350
Fires and fire prevention	350
The patient	351
Welfare of the patient	351
Voluntary service, voluntary workers	351
The general practitioner and his patients	351
Transport of patients	351
Hospital care	351
Discharge of patients	354
Home care, after-care	354
Special departments	354
Administrative offices	354
Wards	354
Operating suites	355
Pharmacy	356
Laboratories	359
Rehabilitation	359
Departments for special therapy	359
Intensive care units	360
Special hospitals and units	361
Out-patient	361
Casualty and accident	363
Day hospitals	365
Infectious diseases and isolation	365
Children	366
Geriatrics and long-stay	366
Cancer	367
Cardiology	367
Urology	368
Surgery	368
Plastic surgery	369
Maternity	369
Psychiatry	370
Corrigendum	viii
Author index	v
Addresses of publications	vi

HOSPITAL ABSTRACTS

Vol. 15 July, 1975 No. 7

HOSPITALS IN GENERAL

914. EICHHORN, S. Integrierte medizinische und pflegerische Versorgung: eine Studie zur Systemplanung im Gesundheitswesen. **[Integrated medical and nursing care: a study of systems planning in the health service.]** *Krankenhausarzt*, Karlsruhe, 1975, April, vol. 48, no. 4, pp. 141-178.

Integrated medical and nursing care includes the following categories: preventive medicine; general medical care; ambulant, semi-ambulant and in-patient specialist treatment; ambulant, semi-ambulant and in-patient rehabilitation; in-patient care of the elderly and chronic sick; home care of the elderly and chronic sick; and other health measures (e.g. general hygiene control). This detailed survey of the existing structure and organization of medical and nursing care and of proposals for its integration is accompanied by 44 references to the literature.

HOSPITALS IN GREAT BRITAIN

915. CHESTER, T. E. **NHS reorganisation after one year: one year later—impressions and reflections.** *Hospital and Health Services Review*, London, 1975, April, vol. 71, no. 4, pp. 117-121.

It is too early to give an informed opinion on the results of the reorganization of the National Health Service (NHS) but the author puts forward his own views based on many discussions with NHS staff at all levels. Some staff problems have arisen because senior officers in the higher age groups decided to retire early when reorganization came. There have also been difficulties in the new authorities getting approval for their permanent management organization. The high rate of inflation and the increased price of oil have caused economic problems which must be distinguished from those of reorganization. Great interest has been focused on the new planning machinery which is expected to be issued shortly. A major criticism of the new structure is that it has one tier too many and the regions and the areas have both come under attack in this connection. Other doubts concern the relationship between health and local authorities and the many committees that have been set up especially the family practitioner committees. It will probably be three to five years before the new organization settles down. The general aim of integration is a sound goal and several other countries (Sweden, New Zealand, Australia, Canada, the United States and West Germany) seem to be moving in the same direction.

916. EVANS, A. M. **A single-district AHA[T]: problems and opportunities.** *Hospital and Health Services Review*, London, 1975, April, vol. 71, no. 4, pp. 121-125.

The author is area administrator of the South Glamorgan Health Authority, one

of eight area health authorities in Wales. It is the main centre in Wales for regional and sub-regional specialties and is the only 'teaching' authority in Wales. Work load in 1974 totalled 65,693 in-patient discharges and 634,686 out-patient attendances. Industrial unrest in the health service during the past year has added to its many other problems. The current economic climate has increased the problems of reorganization and financial restraints highlight the dilemma of deciding on priorities in the allocation of resources. Soon after reorganization the new authority reappraised all existing plans and development proposals. The situation in Cardiff was complicated by the need to rationalize services following the commissioning of the new University Hospital of Wales. A consultative document setting out broad principles as guidelines for long-term strategy was issued in May 1974. The author points out some of the differences in structure between Wales and England. He describes the committee and executive structures and the organizational changes in South Glamorgan since reorganization. Objectives for 1975/76 include the development of community-based services and the alleviation of deficiencies in the long-stay hospital sector.

HOSPITALS IN OTHER COUNTRIES

917. THYGESEN, K. Et lille sygehus der får lov til at fortsaette. **[A small hospital which is allowed to continue.]** *Sygeplejersken*, København, 1975, April 23, no. 16, pp. 26-27.

Skanderborg Hospital, built at the turn of the century, has 140 beds in two- and three-bed rooms, and an occupancy rate of 101.4 per cent, i.e. some patients have to sleep in the corridors. The town lies some 12 miles from the University city of Aarhus with its two teaching hospitals, with which there is an important level of co-operation in laboratory services, X-ray, specialist consultancy, etc. Without this, the hospital, which treats between four and five thousand patients a year (of which 3,000 are surgical cases) would have had to close long since. The county council has, however, decided to continue to operate the hospital until at least 1985.

918. REXED, B. Institutionssjukvårdens utformning och omfattning—under utveckling. **[Hospital care planning and scope—under development.]** *Sjukhuset*, Göteborg, 1975, vol. 52, no. 3, pp. 129-136.

The technology already exists for effecting all the improvements in medical care we are likely to see in the next 10 years, and the results are available in the scientific press. The health service in Sweden currently employs 250,000 to 300,000 people—more than either of the two traditional national industries, agriculture and forestry, or fisheries. By 1985 there will be 27,000 doctors—11,000 more than at present, 11,000 dentists instead of the present 7,000 and 85,000 nurses against 50,000 now. In other words, there will be no shortage of trained staff in the foreseeable future. Likely future developments involve an extension of low level district health care and out-patient services based on health centres, the health service evolving into a continuous process of preventive care. This will involve radical changes in the therapeutic hospital system. The care of the aged and long-stay care in general will have to develop considerably,

as the population over 70 increases from 600,000 to over a million. The results of the many debates on the future of the hospitals and their staffing should now begin to bear fruit. Psychiatric-social factors will require more consideration in the competitive society. There are at present no fewer than 140 different training courses in ward care—this field requires rationalization. The Swedish health service currently costs from six to eight per cent of the gross national product, and the cost is expected to rise to over 10 per cent within the next 10 years. It is up to the public and its elected representatives to decide how these vast sums should best be exploited so as to improve the health of the nation.

919. WEGMILLER, D. C. and PLATOU, C. N. **Looking backward. planning forward.** *Hospitals*, Chicago, 1975, March 1, vol. 49, no. 5, pp. 57-59.

Fairview-Southdale Hospital, Edina, Minn., one of the constituent hospitals of Fairview Community Hospitals, had since 1965 been serving an area in Dakota County. Increases in population led to a detailed study of health service needs for the district and in 1971 it was decided to establish an ambulatory care centre in Dakota County to provide the following basic services: emergency first aid care; emergency transport; out-patient diagnostic and ancillary services; public health education; and co-ordination of school, public and mental health services. Construction started in December 1974 and there is to be a four-phase development over 10 years: the first phase, the community health centre, will be operating by August 1975. Details are given of the planning procedures which were related to a comprehensive health services plan.

PLANNING, DESIGN AND CONSTRUCTION

See Abstract No. 974

BUILDING: TENDERING, ETC.

920. DOERR, KLEINHERNE, and TERHAAR. Drei Krankenhäuser bauen in Kooperation. **[Three hospitals build cooperatively.]** *Krankenhaus*, Stuttgart, 1975, March, vol. 67, no. 3, pp. 97-99.

In 1971 three hospitals in the Münster region (North Rhine/Westphalia) which were to construct new buildings decided to work together with the object of saving time and money. A committee of nine (two members of the board of trustees or building committee and the chief administrator from each hospital) was set up. This committee, which had an advisory and recommending function, worked out with the planner and his collaborators the co-ordination of building procedures. It prepared tenders which covered the requirements of all three hospitals for nearly 80 per cent of construction work for a total of 1,265 beds occupying 316,600 cu.m. The construction of the hospitals began in 1972, 1973 and 1974 respectively, thus making possible optimal use of construction capacity and the market situation. The joint procedure enabled advantage to be taken of a larger volume of construction work and the long-term deployment of labour and materials.

CONSTRUCTION METHODS AND BUILDING MATERIALS

See also Abstract Nos. 922, 924

921. THIEDE, G. Krankenhausbau in Stahlbetonfertigteilen. **[Hospital building using ferro-concrete components.]** *Krankenhaus*, Stuttgart, 1975, March, vol. 67, no. 3, pp. 99-105.

The author, the architect responsible for all the buildings, describes the construction of four new hospitals in North Rhine/Westphalia in which prefabricated reinforced concrete components were used. With the exception of the foundations, the traffic cores and special structures, the framework of the hospitals was built from prefabricated vertical blocks (extending over several floors) and ceiling blocks. The tenders from the firms using prefabricated components were lower than those of other firms. Construction was speeded up: the skeleton of one hospital of 76,000 cu.m. took five months to assemble and another of 93,000 cu.m. took six months. The cost for three of the hospitals was DM35.12 net per cu.m.

HOSPITAL DESIGN

922. MIKHO, E. and DELRUE, J. **Hospital building for developing countries: a system approach.** *World Hospitals*, London, 1974, vol. 10, no. 3, pp. 150-162.

Problems relating to the design of hospitals in developing countries include: (i) they are regarded as a specific category, possibly limited in standards and performance; (ii) they have been conceived as one-off hand products with frozen-type plans; (iii) developing countries tend to be short of money and expertise, especially skilled health manpower; (iv) the climate has an effect on hospital building and operation; and (v) these countries, like others, are going through a period of increase in population, social change and rising standards and advances in health technology and sciences. Decisions concerning the design of building and running a hospital can have both immediate and long-term important consequences in the economic and social fields. A large-scale governmental building programme can only be carried out satisfactorily on the basis of a systems approach. The building process is built up of a number of steps, namely: brief, design, building (which includes production and construction), commissioning and evaluation. In this paper the authors describe: (i) briefing systems and functional programming; (ii) the design system, including standard room layout and shape, multipurpose structures, master planning and communication, and energy network and master grid; and (iii) the building system, including permanent and adaptable parts and building sub-systems development. Many charts, diagrams and plans are included in the paper.

DESIGN OF INDIVIDUAL GENERAL HOSPITALS

923. **The Somerset Nuffield Nursing Home, Taunton.** *Hospital Development*, London, 1975, March/April, vol. 3, no. 2, pp. 14-17.

This new nursing home is linked to a typical Victorian house, which has been

converted to staff accommodation and consulting room suites. The new building contains an operating suite, diagnostic X-ray department, administrative offices and 30 single patient rooms. The patients' rooms are single-storey and radiate from the central core in two wings. The X-ray department, administrative offices and kitchen form a third wing. Each wing has central nurses' station and sisters' office. All patient rooms have monitoring equipment; each is provided with a self-contained toilet unit, fitted wardrobe and a wall-mounted shelf unit. Each room is also equipped with nurse-call facilities, remote control television set, piped radio and telephone. Plans of the home and a typical patient's room are included.

924. STERN, W. M. **Economic modern hospital construction at Eugene Marais Hospital, Pretoria, South Africa.** *Structural Engineer*, London, 1974, May, vol. 52, no. 5, pp. 169-181.

This 230-bed hospital has about one-third of its beds in single rooms. Among its facilities are five laminar flow operating enclosures, four standard operating theatres, diagnostic X-ray department, doctors' consulting rooms and a dispensary. The total suspended concrete floor area is approximately 8,350 sq.m. spread over five floors. This paper outlines the design considerations and evaluates the structural arrangements. It attempts to illustrate that a hospital structure can be economically constructed at relatively short notice provided a systematic approach without preconceived ideas is adopted. The economy of structure was the result of judicious use of all available conventional building materials; no special processes or specialist builders were required. Plans and photographs are included.

DESIGN OF SPECIAL DEPARTMENTS

925. THOMPSON, A. S. **First principles of catering design.** *Hospital Engineering*, Stevenage, 1975, April, vol. 29, pp. 11-12.

This paper presents a checklist which should be of some use to the caterer when he starts to prepare a blueprint for a new catering department. It is in two parts: (i) forecast the future demand for the number of meals required, including number of in-patients and out-patients, visitors, staff catering and special catering functions; and (ii) factors influencing the meal pattern, including cost, nutritional requirements, ethical considerations, length of stay in hospital, distance from kitchen to service points and method of catering to provide required menus.

926. ROCHAIX, M. and CLEMENT, J.-M. La nouvelle direction générale du centre hospitalier régional de Bordeaux. **[New administrative headquarters for Bordeaux Regional Hospital Centre.]** *Techniques Hospitalières*, Paris, 1975, Jan., vol. 31, no. 352, pp. 32-35.

A new administrative centre was built in 1974 for the Bordeaux Regional Hospital Centre, following reorganization of its management. Each service was allocated 20 per cent more space than its present requirement to provide for future expansion. The four-storey building has an unusual facade of prefabricated white panels. Sound insulation is provided by false ceilings, cavity walls and the housing of noisy technical installations on a terrace. Only common rooms have air-conditioning. Offices are

allocated according to function and accommodate from five to 25 staff to ensure team work. Facilities include a 200-place conference room which can be divided into three, a library, canteen, and small rooms in the reception area for interviewing visitors.

927. NATIONAAL ZIEKENHUISINSTITUUT. De bouwkundige opzet van het laboratorium voor klinische chemie. **[Architectural layout of the clinical chemistry laboratory.]** Utrecht, Nationaal Ziekenhuisinstituut, 1975, 105pp. fl.12.50.

Following an introduction, this study is in seven parts: (i) description of the functions of the laboratory; (ii) architectural layout; (iii) analysis of the various areas based on a study of 12 laboratories; (iv) analysis of the work of the 12 laboratories; (v) results of net area analyses; (vi) determining the area of the laboratory; and (vii) finishing and equipping. Photographs, plans and diagrams are included. [This abstract has been prepared from an English summary of the study.]

DESIGN OF SPECIAL HOSPITALS OR UNITS

928. BJÖRKMAN, A. and RAMTZÉN, G. Lövgärdets och Kärra nya sjukhem i Göteborg. **[The new Lövgärdet and Kärra long-stay homes in Gothenburg.]** *Sjukhuset*, Göteborg, 1975, vol. 52, no. 3, pp. 140-144.

Nine long-stay, minimum care nursing homes for the elderly have been opened in Gothenburg since 1968, providing 1,300 beds. At the time of planning in 1965 the waiting list for nursing home places was 600. The first seven homes were built as a series by 1970. Research has shown that wards for about 70 patients are the most economical to run, so Kärra nursing home has 72 beds and Lövgärdet 128 (twice 64). The Lövgärdet home is part of a centrally-sited community centre comprising a special school, a restaurant and hotel, an old people's service block, a library and shops. The two homes are built on the double corridor system, visitors passing an information desk on entry. The Kärra home is built of prefabricated room elements on a steel frame, the whole base floating like a boat on a wet clay subsoil. The exterior resembles a large private house, and while originally on the edge of town it is now being enclosed by housing, a day care centre and a service centre. The paper is illustrated by two exterior and five interior photographs and a series of artist's impressions of the interior, as well as two sketches of the two homes in bird's eye view.

929. SUNNERVIK, D. Trosa får vårdcentral med nytänkande. **[New ideas in Trosa's long-stay care centre.]** *Landstingens Tidskrift*, Stockholm, 1975, April, vol. 62, no. 4, pp. 56-57.

The planned health centre in Trosa (architects: C. G. Carlstedts, arkitektkontor) comprises two 30-bed wards, consulting rooms for three doctors, a dental clinic, a district nurses' centre, physiotherapy and occupational therapy department, kitchen and pharmacy. The centre is designed as an all-electrically-heated, single-storey 'spider' building with a central axis (common ancillary rooms) and side wings containing the care units. Each 30-bed ward contains an eight-bed special care unit permitting intensive observation of, say, advanced cases of senile dementia, without extra staffing; a saving of 3.6 posts per ward. The two 30-bed wards occupy 1,895 sq.m. or 31 sq.m. per bed—a saving on the 32 to 34 sq.m. suggested by the Swedish Board of Health. The paper is illustrated with a floor plan of the 'special care unit'.

930. Klinika plastické chirurgie a odd. popálenin Fakultni Nemocnice v Praze 10. **[Plastic surgery clinic and burns department, Prague Teaching Hospital 10.]** *Architektura CSR*, Praha, 1974, vol. 33, no. 2, pp. 85-87.

This building comprises two operationally connected, but architecturally separated parts: the plastic surgery department with nine storeys, including two below ground; and the burns department with five storeys, including two below ground. The structure is of 27 cm. vertical steel columns spaced at a 7.20 m. module and horizontal reinforced concrete slabs 20 cm. thick and produced by the lift-slab technique. A plan, elevations and photographs of a model are included. [This abstract has been prepared from an English summary of the paper.]

931. BJÖRKMAN, A. and JOHANSSON, R. Vårdbyggnad A vid Lillhagens sjukhus invigd. **[Inauguration of 'A' Block of Lillhagen Hospital.]** *Sjukhuset*, Göteborg, 1975, vol. 52, no. 3, pp. 122-124, 127.

Planning for A Block, the 224-bed acute psychiatric wing of Lillhagen Hospital (architects: White Arkitekter) commenced in 1971 with the setting up of staff study groups. Their recommendations included: small wards; small ward kitchens; privacy for individual patients, particularly for them to be able to write without being overlooked; separate rooms for noisy activities such as music; a library; and separate treatment facilities. The eight-storey block, built in park-land, is of prefabricated concrete, with lightweight walling. All windows can be opened, and a heat exchanger saves S.kr. 140,000 (£15,000) a year. There are 14 wards, each with 16 beds, on the upper seven storeys; a local public branch library and other public rooms occupy the ground floor. The paper is illustrated with plans of the ground floor and a ward floor, diagrams of four ways of furnishing a four-patient room, and four interior and two exterior photographs.

WARDS AND PATIENTS' ROOMS

See Abstract No. 1009

ENGINEERING SERVICES

ELECTRICAL INSTALLATIONS AND EQUIPMENT

932. Une innovation à Bourges: le tout-électrique en milieu hospitalier. **[An innovation at Bourges: the all-electric hospital.]** *Techniques Hospitalières*, Paris, 1975, Jan., vol. 31, no. 352, pp. 65-67.

Reconstruction of the chest centre at Folie-Bâton, Bourges, will consist of: (i) establishment of a service for non-tubercular chest diseases; (ii) modernization of the building where tuberculosis is treated; and (iii) construction of an out-patient department. The first part of this plan has been completed and is an all-electric hospital, as this proved to be the least expensive. It also provides an even temperature, air-conditioning which precludes draughts, and clean air. The system is based on the mechanical recovery of 70 per cent of hot air at the moment it is being exhausted from

the building. The hot air circulates in an exchange battery, which recovers the heat and transfers it to the evaporator and condenser and eventually to the chamber where air coming from the outside is heated. In summer the evaporator cools the air. All these operations are programmed. Each circuit leads to a meter which makes it possible to establish the cost of running each installation, i.e. heating, cooling, recovery of heat, ventilation, air purification, etc. The performance of the installations proved to be excellent from the point of view of the patients' well-being and of the management.

ARTIFICIAL LIGHTING

See Abstract No. 935

COMMUNICATION SYSTEMS

See Abstract No. 1029

VENTILATION AND AIR-CONDITIONING

See also Abstract Nos. 1010, 1011

933. GRÜN, L. and POSCH, J. Hygienische Prüfung und Überwachung von lüftungstechnischen Anlagen in Krankenhäusern. **[Inspecting and controlling the hygiene of air-conditioning installations in hospitals.]** *Das öffentliche Gesundheitswesen*, Stuttgart, 1975, March, vol. 37, no. 3, pp. 131-137; summary in English p. 131.

Inspection of the hygiene of hospital air-conditioning installations should be carried out by independent bodies such as the Medical Inspection Offices and university institutes of hygiene. In new buildings plant should be inspected after it has been working for a few days and before the hospital comes into use. Inspection in existing hospitals should if possible take place annually and at least every other year. This paper discusses suitable procedures for controlling airborne micro-organisms, including sampling, and for the checking of air flow, temperature and relative humidity. A checklist of main inspection points is given under the following heads: air intake; prefilter; intake chamber and duct; cooler; humidifier; filter; ducts; rooms; and air outlets.

934. KRÜGER, D. and MELCHERT, H. **Technological aspects of hygiene in planning and supervision of air conditioning plants for rooms with special cleanliness requirements.** *Drugs Made in Germany*, Aulendorf, 1975, March, vol. 18, no. 1, pp. 3-8, 10, 12-14, 19-22, 24, 26-28.

The first part of this paper describes the physical, chemical and biological requirements demanded from air-conditioning technology for use in clean rooms in the medical and pharmaceutical fields. To help put the relevant problems and the proposals for improving individual technical processing steps on a sound footing, some of the results obtained during microbiological testing of various air-conditioning plants are reported. Maximum organism counts are proposed for assessing the bacteriological

hygiene of clean rooms. The second part discusses the problems of continuously monitoring air-conditioning plants. Mastering the complex technical operations is becoming progressively more difficult, among other reasons for lack of suitably or correctly trained staff—regrettable incidents, especially in hospitals, have been the consequence. As a result, a check list containing the principal technical and biological function controls is proposed. Using a checklist can provide an effective practical method for monitoring air-conditioning plants.

935. SJUKVÅRDENS OCH SOCIALVÅRDENS PLANERINGS- OCH RATIONALISERINGSINSTITUT. Sjukhusmiljö—en intervjuunderssökning av patienter und personal. **[The hospital environment—a study based on interviews with patients and staff.]** (Spri rapport 13/74) Stockholm, Spri, 1974, 121pp.

Interviews were held with patients and staff to obtain their views on the environment in hospital buildings with varying technical standards. The report is in three parts: (i) background and purpose of the study; (ii) background variables; and (iii) results. The interview covered seven areas: room temperature, draughts, odours, humidity, lighting, acoustics and lavatories. The results are presented in tables and graphs and are discussed. Newer buildings were generally considered better for draughts, lighting, noise and lavatories; differences between old and new buildings for temperature, humidity and odours were minimal. Younger people were more dissatisfied with temperature and humidity, older persons with odours and draughts. [This abstract has been prepared from an English summary of the report.]

936. SKIBA, H. Klimatisierung von OP-Räumen mit Hilfe der Rein-Raum-Technik. **[Air-conditioning of operating theatres using clean room techniques.]** *Sanitär- und Heizungstechnik*, Düsseldorf, 1975, vol. 40, no. 1, pp. 19-24; vol. 40, no. 2, pp. 66-72.

A detailed description is given of the use of what is called the 'clean room technique' for the air-conditioning of operating theatres. This involves the use of the 'absolute filter' and turbulence-free laminar flow of air round the operating table. Descriptions are also given of an operating 'tent' developed in the United States and a Swiss prefabricated operating 'cell', which apart from four metal feet on the floor is entirely independent of the building structure. There are 22 references to the literature.

INSULATION AGAINST SOUND AND TEMPERATURE

See Abstract 935

MAINTENANCE OF BUILDINGS AND EQUIPMENT

See Abstract No. 941

SANITARY EQUIPMENT AND FITTINGS

See also Abstract No. 935

937. TUSON, G. **Sanitation in hospitals.** *Hospital Engineering*, Stevenage, 1975' April, vol. 29, pp. 3-9.

The development of major hospitals has increased the complexity of sanitation problems, creating the need for a new appraisal of sanitation hazards and engineering solutions. This paper discusses some of the problems involved including: the increase in the number of sanitary applicances per bed; the design of modern sanitary appliances; architectural design based on planning requirements; the increase in engineering service requirements; the design requirement that all pipework should be hidden in the structure; the problems of co-ordination; the use of internal manholes; the lack of expertise in design; and the use of British Standards Institution Code of Practice 304.

EQUIPMENT, FITTINGS, FURNITURE

BEDS, COTS, ETC.

938. CATCHLOVE, B. R. and SPENCER, S. **Development of an all-purpose acute hospital bed.** *National Hospital*, Chippendale, N.S.W., 1975, Jan./Feb., vol. 19, no. 1, pp. 21-23.

After the new 652-bed Royal North Shore Hospital, Sydney, had used a prototype all-purpose bed over a period of 18 months, during which modifications and a detailed evaluation were carried out, a final specification was drawn up. The bed is to be of stainless steel and of non-variable height. The mattress base is 75 inches by 34 inches and 27½ inches above the floor. The head end is removable with adjustable backrest; the foot panel telescopic, extendable for use with extra long mattresses and a linen changing shelf. The bed functions as a trolley and is adaptable for intensive care nursing and is self-contained. It will travel to the operating suite and, with the head end removed, will be used for anaesthestizing patients. The paper includes a full specification.

EQUIPMENT GENERALLY

939. SURAND, G. and HOQUET, F. Du choix des équipements à l'assistance publique de Paris. **[Selection of equipment by Paris Assistance Publique.]** *Techniques Hospitalières*, Paris, 1975, Jan., vol. 31, no. 352, pp. 36-39.

Because of its own special characteristics the Paris Assistance Publique is an important customer for medical equipment. This study analyses the selection, purchase and maintenance of non-consumable equipment. After an assessment of equipment needs by the medical administrators, heads of services and the surveillance commissions, money is allocated according to the available funds. The equipment is divided into: small, with a value of less than 20,000F; and heavy, over 20,000F. The former is bought either by agreement with suppliers or through a purchasing group. Purchase of the latter has been regulated since 1971 by a new general policy. Technicians of various specialties have been recruited to select the equipment which is most efficient

and easiest to maintain and specialist advisory bodies have been established. Special commissions for the rationalization of equipment composed of doctors, administrators and technicians have been established; their task is to prepare an inventory by specialties of the equipment which is available on the market, to assess its advantages and disadvantages, to test it for a few months in hospitals and to participate in the choice of equipment. This has resulted in reductions in prices and adjustment of equipment to the needs of hospitals. It would however be desirable if these commissions could determine the minimum needs for each specialty and to study the renovation of old equipment.

ELECTRONIC EQUIPMENT

940. WATSON, B. W. **The Department of Medical Electronics, St. Bartholomew's Hospital—the first ten years.** *Biomedical Engineering*, London, 1975, March, vol. 10, no. 3, pp. 98-104.

The Department of Medical Electronics at St. Bartholomew's Hospital, London, consists of three sections: electronic engineering, which offers a day and night 'on call' service for patient monitoring and resuscitation equipment; clinical measurement; and biological signal processing. The director of the department is also responsible for biomechanical engineering, which covers repair of items of surgical and theatre equipment as well as the development of instruments requiring mechanical and electronic engineering and for St. Bartholomew's Hospital Research Unit for the Handicapped. One of the biggest problems in a multidisciplinary department of this kind is to find staff who are used to working in a hospital and who have a knowledge of basic physiology and clinical medicine. Some examples from the research and development programme are described. These include the measurement of blood flow, computer developments, work on urinary incontinence, renal dialysis, radiotelemetry, speech aids and biophysics. The work of the Research Unit for the Handicapped has ranged over problems of toileting, bathing, chairs, and the development of concepts for creating new environments for the handicapped. Other work of the department has covered the development of measuring techniques in cardiology and special instruments and transducers which are of great value to research workers in the hospital and college. A diagram illustrates the administrative structure of the department and photographs show some equipment. Forty-seven references are listed.

STAFF GENERALLY

RECRUITMENT

See Abstract Nos. 945, 954, 955, 1057

SALARIES AND SUPERANNUATION

See also Abstract No. 957

941. HENDERSON, S. **An incentive bonus scheme for maintenance staff.** *Hospital Engineering*, Stevenage, 1975, April, vol. 29, pp. 17, 19-24.

This paper describes the bonus incentive scheme introduced by the Sunderland

Area Health Authority. The scheme was prepared by the Department of Health and Social Security who supervised its introduction as a pilot study. The scheme is based on the principle of measured work and revolves around a National Health Service Standard Work Measurement Data Reference Manual. This manual contains a considerable number of standard times for elements of work which can be built up so that individual times can be given for the great majority of hospital jobs. The opportunity for earning bonus is calculated by performance against these standard times. The hub of the scheme revolves round the planner-estimators who were selected from craftsmen and trained for this work. The procedures followed, including requisitioning, are described.

STAFF MANAGEMENT

See also Abstract Nos. 953, 957, 980

942. BURKE, R. J. and GOODALE, J. G. **Developing a common performance evaluation system for all employees of a hospital.** *Hospital Administration in Canada*, Don Mills, Ont., 1975, Feb., vol. 17, no. 2, pp. 26-30.

A previous paper described attempts to develop behaviourally-based rating scales for evaluating the performance of staff nurses in two different hospital settings [see *Hospital Abstracts*, Vol. 14, Abstract 651]. This paper describes the successful development of scales for nearly all jobs in an 800-bed hospital. The total project took about five weeks to complete. The specific steps involved were: (i) orientation of supervisory staff; (ii) identifying and defining areas of performance; (iii) generating behavioural examples of the areas of performance; (iv) assigning incidents to performance areas; (v) assigning scale values to the incidents; (vi) training in use of scale; and (vii) training in the conduct of the appraisal interview. The value of the scales is discussed.

STAFF TRAINING

See Abstract Nos. 946-949, 998, 1013

STAFF WELFARE

See also Abstract Nos. 982, 986

943. FARRANT, E. M. **The occupational health service at the Middlesex Hospital, London.** *Nursing Mirror*, London, 1975, May 1, vol. 140, no. 18, pp. 46-49.

An occupational health service for all staff in the Middlesex Hospital group was started in early 1973. The functions of the service are described. They include: health assessment, immunization of staff, health education and counselling, environmental control and accident prevention, minor treatment service, rehabilitation and resettlement, and record keeping.

SPECIAL CLASSES OF STAFF

MEDICAL STAFF

See also Abstract No. 1048

944. COHN, R. E. **The medical director in a community hospital: a perspective.** *Hospital Topics*, Chicago, 1975, Jan./Feb., vol. 53, no. 1, pp. 4-5, 30-31, 51

The author reflects on the functions of a full-time medical director based on his 5½-years' experience in an American community hospital. He describes the relationship of the director to the hospital board of directors, the professional committee of the board, the education committee, the administration, medical staff and nursing staff. His responsibility in the fields of medical education and public relations are also briefly outlined.

NURSING STAFF

See also Abstract Nos. 961, 1003, 1057

945. GREAT BRITAIN. OFFICE OF POPULATION, CENSUSES AND SURVEYS. SOCIAL SURVEY DIVISION. **Reserves of nurses: an enquiry carried out on behalf of the Department of Health and Social Security, by Judy Sadler and Tony Whitworth.** London, Her Majesty's Stationery Office, 1975, vi, 77pp. £1.80

This is the report of a survey of qualified nurses who were not, at the time of the interview, employed in the National Health Service. The survey was carried out at the request of the Committee on Nursing [see *Hospital Abstracts*, Vol. 13, Abstract 34]. A sample of 709 was selected using the relevant information on the 1971 census forms; interviews were obtained from 628 (89 per cent) of these. The report covers: (i) personal characteristics, including family circumstances; (ii) past and present employment; (iii) future intentions towards nursing; (iv) contact with nursing since leaving; and (v) attitudes towards women working and return to nursing. The results are presented in tables and discussed. The general attitude towards return to work was favourable, but any successful recruitment drive would have to take into account the varied (and in many cases fairly short) hours which the potential returners want to work, in particular those arrangements which would need to be made for young children.

946. FLOYD, G. J. **Team teaching: advantages and disadvantages to the student.** *Nursing Research*, New York, 1975, Jan./Feb., vol. 24, no. 1, pp. 52-57.

In order to test an instrument for its ability to identify the advantages and disadvantages of team teaching in baccalaureate schools of nursing in the United States a questionnaire has been completed by 97 undergraduate nursing students. Team teaching is defined as two or more teachers with different preparation, abilities and nursing skills co-operating and sharing in the planning, carrying out and evaluation of the teaching of a group of students. The results of the enquiry are set out in tables which show the numbers and percentages of students identifying 15 advantages and eight disadvantages. These figures should be seriously studied by nursing institutions and teachers.

947. HILLIARD, M. **Orientation and evaluation of the professional nurse.** Saint Louis, Mosby, 1974, x, 168pp. £2.80

The cost of in-service orientation programmes for newly-qualified nurses is mounting, but they seem to have little effect on frustration, lack of job satisfaction and rapid turnover. This book is based on the philosophy of self-directed learning. It presents a programme that consists of one week of orientation, four weeks' participation in nursing care during which self-directed learning is used, and a sixth week during which the nurse will be evaluated for competence and accountability. The book is in four parts: (i) the problem, determinant and prescription; (ii) process and measurement; (iii) information specific to practice of nursing—examples of procedures for self-directed learning; and (iv) conclusions and recommendations.

948. TAYLOR, C. R. **Continuing education for nurses.** *Nursing Times*, London, 1975, April 10, vol. 71, no. 15, occasional papers, 29-32.

This paper reports on a visit to the United States to study the provision made there for the continuing education of registered nurses. Attention is drawn to achievements, current issues and discrepancies. There is sufficient evidence in the United States to suggest that continuing education will soon be a mandatory requirement for re-licensure in the majority of states despite the inherent problems. The situation in England and Wales leaves a lot to be desired. The need has been recognized and it is an opportune moment for action. A survey should be carried out as soon as possible of nurses' educational needs and the resources available. The findings should be used in establishing a trial programme. Interim measures include: (i) a stronger move towards more systematic in-service education; (ii) planning for the preparation of teachers; (iii) introduction of the concept of continuing education into all learner programmes; (iv) consideration of how a national system of continuing education might operate; and (v) means should be sought for encouraging the interchange of ideas among those already involved in this field.

949. ELLIS, F. **Comprehensive nurse training in Scotland—a prelude to Briggs.** *Nursing Mirror*, London, 1975, April 10, vol. 140, no. 15, pp. 46-50.

Centralization of all nurse training in the Dundee area in the Dundee College of Nursing in May 1969 made it ideal for an experimental study of a comprehensive form of training. This provides for two modules of experience in each of the four major disciplines—general, mental, mental handicap and paediatrics, a module for casualty and operating theatre, a module for special experience and a double module of 15 weeks broadly embracing community aspects. Twenty-eight weeks are set aside for theory in the form of six study blocks in the College, making a total of 120 weeks or 2½ years. The nurse may then choose a clinical area in which to spend the final 24 weeks leading to registration in the chosen discipline. Details of intakes and courses are given and a sample three-year study programme is reproduced.

950. LEFEUVRE and others. La chaussure de l'infirmière. **[Footwear for nurses.]** *Techniques Hospitalières*, Paris, 1975, Jan., vol. 31, no. 352, pp. 50-62.

Nurses' footwear is of great importance since they walk from 4.5 km. to 14.5 km. daily. An enquiry by the Paris Assistance Publique in French and foreign hospitals has shown that in the great majority of French hospitals there are no special rules

regarding shoes; sometimes white or silent shoes are required and a few hospitals provide one pair of shoes per year. There are no special rules in Holland and Sweden, in Switzerland the style is defined, in Belgium, Canada, Lebanon and United States white and silent shoes are required, in Great Britain black, low-heeled, silent shoes are required. In Switzerland, Great Britain and United States the cost of shoes is either tax deductible or met from an allowance. For operating theatres disposable or plastic bootees are generally used. In the Assistance Publique hospitals nurses are issued once a year with one pair of white composition shoes or sandals. The ordering and delivery of footwear at hospital level is described. The enquiry showed that only 15 per cent of nurses wear these shoes because they have many disadvantages. Shoes are disinfected only in some specialized services. The importance of suitable flooring and the disadvantages of underfloor heating are stressed. The study group recommends shoes with white, perforated, laced, closed leather tops, at least 7.00 cm. wide, and crepe, rubber or composition non-slip soles. Wooden soles are undesirable. Various suggestions are given regarding choice, fitting, cleaning, distribution and disinfection of footwear. It may be concluded that nurses' shoes should be safe, solid, comfortable, silent and aesthetic. There are 14 photographs.

951. KAYSER, J. S. and MINNIGERODE, F. A. **Increasing nursing students' interest in working with aged patients.** *Nursing Research*, New York, 1975, Jan./Feb., vol. 24, no. 1, pp. 23-26.

A total of 311 students of varying grades at the University of San Francisco School of Nursing were asked about their attitudes to working with children, adults, and the elderly as well as to work in certain other specialist fields. The results show that there was little interest in work with the elderly. Those preferring to specialize in nursing homes varied between 3.2 per cent and 6.1 per cent (according to grade) and those expressing a desire for work with the elderly varied between 11.8 per cent (freshmen) and 23.5 per cent (registered nurses). It is suggested that schools of nursing should include gerontology in their curricula and that students should have clinical experience in establishments for the elderly.

952. MARKS, I. and others. **A symposium on the psychiatric nurse-therapist: a new form o f clinical nurse specialist.** *Nursing Mirror*, London, 1975, May 8, vol. 140, no. 19, pp. 46-64.

This symposium describes the training and role of nurse-therapists during a three-year operational research project at the Institute of Psychiatry, Maudsley Hospital, London. The symposium consists of six papers and six case studies. The papers are: introduction and overview; the training of nurse-therapists; patient selection, treatment and outcome; the secondment period; a nurse-therapists' viewpoint; and behavioural psychotherapy in a domiciliary setting. The case studies illustrate nurse-therapists at work in cases of pigeon phobia, agoraphobia complicated by alcoholism, social phobia, obsessive compulsive disorder, non-consummation of marriage, and sexual deviation in a young man.

953. BRENNER, G. Die Aufgaben des Leitenden Krankenpflegepersonals. **[The duties of chief nursing officers.]** *Krankenhaus*, Stuttgart, 1975, March, vol. 67, no. 3, pp. 84-90.

This paper sets out the legal provisions relating to the duties of chief nursing officers

(defined as those wholly responsible for the nursing service of a hospital or specialist department and who have no superior nursing officer) in Western Germany. Chief nursing officers are responsible for all nurses, both those on the wards and in other departments, and for other staff (e.g. domestic workers and cleaners) who are employed directly and exclusively in the care of patients on wards. They also have the following duties: determining the nurses' duty posts and co-ordinating work on the wards; appointments and dismissals; provision of testimonials and certificates; supervision of all nursing staff and their relationships with patients and other staff; enforcement of ward rules (where necessary in agreement with doctors); maintenance of materials and equipment; and co-ordination with medical and administrative staff.

954. BAKER, E. J. **Associate degree nursing students: nonintellective differences between dropouts and graduates.** *Nursing Research*, New York, 1975, Jan./Feb., vol. 24, no. 1, pp. 42-45.

A series of tests to measure their 'non-intellective' characteristics was made on 112 students entering associate degree nursing courses. At the end of two years, analysis of the entrance data showed significant differences between the 73 graduates who completed the course and 32 who dropped out. The former were more mature (older and married), more 'achievement-oriented', more responsible and more self-controlled than the latter. They also showed more acceptable attitudes to other people.

955. JONES, C. W. **Why associate degree nursing students persist.** *Nursing Research*, New York, 1975, Jan./Feb., vol. 24, no. 1, pp. 57-59.

A study has been made of 15 personality factors as measured in 101 associate degree nursing students at Illinois Central College who completed the course and in 19 who dropped out. Those who completed the course revealed a significantly greater need for heterosexuality, achievement and deference: the drop outs indicated a need for 'abasement'. The full results are set out in statistical tables and suggestions are made for further research in this field.

OTHER PROFESSIONAL AND TECHNICAL STAFF

See Abstract Nos. 1013, 1015

ANCILLARY STAFF

See Abstract No. 941

ORGANIZATION AND ADMINISTRATION

See also Abstract No. 981

956. BOER, G. **An integrated approach to make planning work.** *Hospital Financial Management*, Chicago, 1975, Feb., vol. 29, no. 2, pp. 12-14, 16-19.

A hospital is a business institution which needs planning just as much as any other, but planning is carried out at all levels in the hospital and all parts must work together

towards the same goal. It is the manager's job to co-ordinate all the planning activities. In this paper a diagram indicates that in the setting of goals and objectives there must be agreement on the basic philosophy of the institution. A capability profile is used to assess the skills the hospital has to work with and to see how these skills can be used to further the basic goal. A capability profile of a clinical laboratory is used as an example but a profile can be prepared for the hospital as a whole. This technique helps focus the attention of staff members on the resources of the hospital and encourages them to work towards the same goal.

957. HAND, H. H. and HOLLINGSWORTH, A. T. **Tailoring MBO to hospitals.** *Business Horizons*, Bloomington, Ind., 1975, Feb., vol. 18, no. 1, pp. 45-56.

High staff turnover rates in hospitals detract from the quality of patient care and fail to make the optimum use of financial resources. The effect of pay on staff turnover and productivity are discussed. Management by objectives (MBO) is recommended as a particularly effective method of relating salaries and wages to productivity and attrition. An MBO programme with monthly reviews is one of the best means of judging those intangible efforts not readily measurable by normal work measurement methods. A suitable programme is outlined and represented in diagrammatic form.

958. BAYDIN, L. D. and SHELDON, A. **Corporate models in health care delivery.** *Hospital Administration*, Chicago, 1975, vol. 20, no. 1, pp. 40-52.

In response to environmental and economic demands, the past 20 years have seen the development and growth of new types of health institutions based on corporate models. Five such associations are described: (i) the merger; (ii) the joint venture; (iii) the holding company; (iv) the investor-owned national hospital company; and (v) the management contract. All five approaches share a concern with using scarce resources, especially management skills, more effectively.

959. GOODWIN, P. **Why one hospital implemented a formal planning system and how it works today.** *Hospital Financial Management*, Chicago, 1975, Feb., vol. 29, no. 2, pp. 20-23.

Hillcrest Medical Center, Tulsa, Okla., is a 567-bed general hospital which provides special programmes in burn care, rehabilitation medicine and renal dialysis/transplant services in addition to the usual acute care. It is a teaching hospital for medicine, nursing and a number of other disciplines. The hospital has introduced new management techniques over many years and this led in 1967 to the investigation of the role of planning and the design of an action programme to implement a formal planning system. The hospital's concept of planning is based on the principle that planning is the first basic function of management. Many useful tools such as budgeting, management by objectives and regular forecasting can be used in the planning situation. The primary ingredients of a successful planning programme are basic understanding of the concept of planning as a management function and knowledge and acceptance of the sequential process of planning. The orientation of the chief executive officer is of primary importance in organizing the institution for effective planning. The system at Hillcrest Medical Center avoids the need for a more formal, highly structured approach. Its planning looks beyond the hospital itself towards the needs of the community.

960. ROBINSON, G. A. **Functional management: a hospital secretary's view.** *Hospital and Health Services Review*, London, 1975, April, vol. 71, no. 4, pp. 133-134.

The hospital service in Great Britain is predominantly based on a large number of small hospitals, the 'district' being the viable unit of hospital service administration. None of the functional managers responsible for a particular activity has any responsibility for the smooth functioning of the hospital as a whole. This is the duty of the hospital secretary who must co-ordinate the different managerial systems within the hospital. Functional management means a clear line of responsibility from district to operational level for each of certain functions, catering or domestic management for example. Management may be defined as the control of a definite function in terms of the proper use of available resources whereas administration is the supervision or co-ordination of separate functions in pursuit of an overall object. Since the introduction of the Salmon recommendations nurses have been relieved of many non-nursing duties and the responsibility of the hospital secretary for such supporting services as catering, linen, etc., has been crystallized. The application of the functional system to the work of nurses might provide a career structure for the nursing auxiliary and reduce the number of nurses needed. The introduction of functional budgets as proposed by the Department of Health and Social Security is likely to involve a great deal of work.

961. BLAIS, N. and GROULX, D. La gestion des hôpitaux: participation positive des infirmières aux conseils d'administration. **[Hospital management: positive participation of nurses in councils of administration.]** *Infirmière Canadienne*, Ottawa, 1975, Jan., vol. 17, no. 1, pp. 17-23.

This paper reports a study of the extent to which nurses have participated in and benefitted from the administrative councils in hospitals in Quebec. A questionnaire was completed by 76 of the 167 nurses to whom it was sent. Of these 56 per cent hold higher posts, 77 per cent were elected or nominated by their fellow nurses and 80 per cent had the support of other nurses in their hospitals. The great majority integrated immediately or after a few meetings due to their professional experience. They considered that their views were respected; occasionally the subjects discussed were beyond their understanding. Half of the nurses considered the structure of the councils to be efficient and democratic; 60 per cent did not think doctors had more influence than other members. The nurses thought their presence contributed to the improvement of patient care, that hospitals and nurses benefited and that they achieved some changes in hospital organization. The majority thought members should be from the higher nursing grades and that their service on the councils should be extended by a year.

ECONOMICS OF HOSPITAL MANAGEMENT

See also Abstract Nos. 957, 966

962. FOSTER, R. W. **Economic models of the hospital.** *Hospital Administration*, Chicago, 1974, vol. 19, no. 4, pp. 87-93.

In recent years a number of models of hospital behaviour have appeared in the economics literature. This paper discusses briefly the popular economic models. The

economist's concept of efficiency is used as a framework for discussing the implications of the models, particularly their relevance to such questions as appropriateness of hospital costs and incentive reimbursement. The implications of the different models are not always consistent, but there may be surprise at the consistency of some of them.

963. LAYCOCK, E. **Are hospitals operating as efficiently as private corporations?** *Hospital Administration in Canada*, Don Mills, Ont., 1975, Feb., vol. 17, no. 2, pp. 31-34.

This paper presents a comparison of organizational structures and management styles in a hospital and a large private industrial firm in the same district. The comparison covers formal organization, management style, informal organization, span of control, delegation, committees, and planning. It is concluded that charges of inefficiency in hospitals are totally unwarranted. In fact, the management processes between the two industries (health and manufacturing, or the private and public sectors) are quite similar—a result of the type of training programme offered to health services administrators. In addition, because of the size of operations and the management style chosen by the two concerns, the hospital is much more flexible in its functioning, resulting in a higher level of staff motivation and participation.

964. SMEJDA, H. A. **Shared services.** *Hospital Financial Management*, Chicago, 1975, March, vol. 29, no. 3, pp. 10-15, 63.

This paper defines shared services, discusses their advantages and disadvantages, outlines their current status in the United States, and comments on their implications for financial managers. The titles and addresses of 144 organizations providing shared services are listed.

RUNNING COSTS

965. COOKE, N. J. and GRANT, I. W. B. **Cost to National Health Service of social outcasts with organic disease.** *British Medical Journal*, London, 1975, April 19, vol. ii, pp. 132-134.

The hospital medical records of a patient with chronic lung disease and intractable social problems have been analysed. Multiple admissions resulted in the patient spending nearly three years out of seven and a quarter in Edinburgh hospitals and in the performance of repeated and often unnecessary medical investigations. Such patients are a considerable uneconomic expense to the National Health Service, but at present it is difficult to see how their medical and social demands can be met in any other way.

966. LINDAHL, O., WANTULOK, J. and LINDWALL, L. Metod för jämförelse av sjukvårdskostnader mellan samma specialiteter på olika sjukhus. **[Methods of comparing expenditure on the same specialties in different hospitals.]** *Landstingens Tidskrift*, Stockholm, 1975, April, vol. 62, no. 4, pp. 37-38, 40-42.

The current criteria for assessing a department's efficiency are audited costs per patient day or in-patient admitted, out-patient seen or surgical operation. It is difficult to understand such figures unless one has a basis of comparison with other departments practising the same specialty. It is possible to divide costs between: (i) capacity

expenses—cost of equipment and services including maintenance, telephone, post; (ii) staff costs—salaries, training, welfare; (iii) service expenses—porters, laundry, cleaning, etc.; (iv) cost of materials and storage; (v) cost of feeding patients; (vi) cost of diagnosis—X-rays, laboratory tests, post-mortems; (vii) treatment costs; and (viii) other expenses. On the basis of an assumption of identical 'distribution of resources' profiles, a comparison by means of profile diagram was carried out of cost levels in different specialties (surgery, medicine, otology and orthopaedics) at four hospitals. The paper is illustrated by eight profile diagrams showing the results of these analyses by: (i) total cost; (ii) 'sensitive' costs (treatment, diagnostics and materials consumed); (iii) costs of materials and treatment minus intensive care; (iv) intensive care; (v) diagnostics; (vi) fixed costs (total costs minus sensitive costs); (vii) capacity (buildings and maintenance) costs; and (viii) staff and service costs. All of these are per ward day. It is proposed that hospital economics departments should analyse running costs in this comparative manner instead of providing a mass of detail which defies comparison.

967. TATCHELL, P. M. **An economic analysis of hospital costs in New Zealand.** *New Zealand Journal of Public Administration*, Wellington, 1974, Sept., vol. 37, no. 1, pp. 55-66.

The primary aim of this paper is to survey some of the literature on hospital costs (24 references are given) and to set out a number of proposals for measuring and analysing hospital costs in New Zealand. Two measures of cost (per patient day and per case) have generally been used. Seven variables have been shown to be relevant in explaining cost variations: three important ones are diagnostic mix, complexity of cases, and hospital size. A number of questions which need to be the subject of research in New Zealand are listed including the following: factors which account for variations in cost at a given time; whether size is an important factor; possible scope for different management skills; whether diagnostic mix is stable over a short period; whether cost functions are stable from year to year; what the main factors affecting cost inflation in recent years are; and whether the rate of inflation varies.

BED OCCUPANCY, ECONOMIC USE OF BEDS

See Abstract Nos. 1007, 1017, 1052, 1058

APPOINTMENT SYSTEMS, WAITING LISTS

See Abstract No. 1033

OFFICE MANAGEMENT AND METHODS

968. LONGEST, B. B. **Principles of hospital business office management.** Chicago, Hospital Financial Management Association, 1975, [x], 249pp.

The main purpose of this book is to provide the operating principles, analytical approaches and supervisory techniques which the business office manager needs to

accomplish his objective of maximizing revenue while achieving optimum productivity from the resources entrusted to him. There are chapters on: (i) the hospital and its business functions; (ii) the hospital business office and the management process; (iii) accounting and financial management; (iv) the systems approach; (v) organizing the hospital business office; (vi) the business office manager's role; (vii) relationships with other sections of the fiscal services division; (viii) staffing; (ix) planning and using physical facilities; (x) improving work methods; (xi) forms design and control; and (xii) the systems approach to controlling office costs.

DATA PROCESSING

See also Abstract Nos. 971, 979, 1008, 1014, 1016, 1018, 1023, 1035, 1039, 1049, 1050

969. THIES, J. B. **Hospital personnel and computer-based systems: a study of attitudes and perceptions.** *Hospital Administration*, Chicago, 1975, vol. 20, no. 1, pp. 17-26.

A recently completed hospital information system was evaluated in terms of staff attitudes towards computer-based systems. Attitudes were measured: (i) before the system was implemented; (ii) six weeks after it became operational; and (iii) approximately six months later. The study suggested that staff attitudes could be anticipated through analysis of biographical data, and that existing attitudes could readily be modified by new experience. Such insights could provide a basis for identifying potential problem areas before they develop and may suggest the need for special training or orientation programmes to assure the constructive participation of groups with negative attitudes towards computer-based systems.

970. FREIMAN, A. H., SCHEINER, E. and WALSH, D. W. **The clinical information center.** *Clinical Bulletin*, New York, 1974, vol. 4, no. 2, pp. 58-62; vol. 4, no. 3, pp. 91-96.

Recognition of the variety of information being generated continually from clinical sources led to the historically separate functions of medical records and clinical statistics being incorporated in the Clinical Information Center (CIC) at Memorial Sloan-Kettering Cancer Center. The first part of this paper discusses the concept of the centre and the initial planning required to construct such a centralized, multipurpose information system. The second part describes the system which was designed and its implementation. The CIC meets the needs of both the clinical and research units of the Center and combines the previous medical records, cancer registry and clinical statistics functions. It is divided into two sections: information processing and biomedical data. The functions and procedures of each section are described and sample forms are reproduced.

ORGANIZATION AND METHODS, WORK STUDY

See Abstract No. 1042

MEDICAL RECORDS

See also Abstract Nos. 970, 1034, 1035, 1039

971. GORDON, B. L. **Simplified medical records system: a directory of medical terminology.** Acton, Mass., Publishing Sciences Group, 1975, xv, 270pp. £7.00

This publication is a directory or remembrancer of precise professional and lay terms with corresponding identification numbers. It serves as a lexicographic tool for convenient manual data generation and documentation and as a 'feeder' of pertinent, workable information to a computer. The system is in five parts: (i) administrative and clinical terminology; (ii) physical signs, laboratory tests, radiology and electrocardiography; (iii) nomenclature and classification; (iv) abbreviations of clinical and physiological phenomena; and (v) drugs. The use of the system is outlined.

HOSPITAL STATISTICS

See Abstract Nos. 970, 1035

HOSPITAL ACCREDITATION AND SIMILAR SCHEMES

See Abstract No. 1013

FINANCE AND ACCOUNTING

972. BAYLISS, G. **Problems of a treasurer: or an open letter to the Secretary of State for Social Services.** *Hospital and Health Services Review*, London, 1975, April, vol. 71, no. 4, pp. 125-129.

The author expresses personal views as to how some of the aims of the reorganization of the National Health Service (NHS) could be fulfilled. Three special problems face the hospital treasurer: (i) he has an operational as well as an advisory role; (ii) he lacks adequate supporting staff; and (iii) his life is governed by deadlines to a greater extent than that of other officers. Several ideas are put forward for the Secretary of State to consider. These include: (i) reconstitute personnel policy and function, unify staff service conditions, speed up the production of advance letters, have an experienced salaries and wages officer on the management side of each Whitley Council, provide suitable training and experience for NHS CIPFA candidates and bring travelling allowances up to those paid by local authorities; (ii) reduce the number of circulars and word those that are issued more clearly and concisely; (iii) spread positive management problems and eliminate negative ones, consider the staff needed to operate the functional budgeting system and other cost effectiveness and management audit techniques, collect statistics on a financial year basis and try to make savings by reducing heating and lighting; (iv) state what is the absolute minimum required to satisfy Parliament in the preparation of 1974/75 annual accounts and stick to it and get the Accountant General Department's staff to visit authorities in the field; and (v) examine the recruitment and quality of the higher professional staff in the light of current social policy and make NHS fringe benefits comparable with the best of those in other parts of the public service.

FINANCE

See also Abstract Nos. 968, 1040

973. DONLON, V. W. **Statistical methods to forecast volume of service for the revenue budget.** *Hospital Financial Management*, Chicago, 1975, April, vol. 29, no. 4, pp. 38-41, 44-47.

A comparison of three techniques (percentage change, least squares regression, and multiple regression) for forecasting revenue budget has been made at St. Joseph Hospital, Lexington, Ky. The conclusion is that the future behaviour of the service output of patient days will be assessed with significantly greater accuracy by means of multiple regression analysis than by the other two methods. It is also concluded that patient days should be used to project general room service revenue but not ancillary revenue.

974. MYERS, K. G. **Planning—for $$ too—cuts building problems.** *Hospital Financial Management*, Chicago, 1975, April, vol. 29, no. 4, pp. 26-30, 32-35.

The systematic planning of the finances of hospital capital projects is discussed in detail. The process has the following stages: division of the project into six separate and controllable phases; providing financial considerations in each phase; reviewing project feasibility at the completion of each phase; and assigning total responsibility to a skilled individual. The six phases which form the first stage are as follows: preliminary analysis; detailed financing; economic feasibility study; health planning agency approval; detailed architectural design; and project implementation. Each of these phases is outlined.

975. GILBERT, R. N. **Present value depreciation—the answer to the capital crisis?** *Hospital Financial Management*, Chicago, 1975, March, vol. 29, no. 3, pp. 26-36, 40-41.

The causes of the current hospital capital fund crisis in the United States are reviewed. It is estimated that 35 to 45 per cent of all hospital beds are in institutions not meeting the minimum United States Public Health Service standards for hospitals. This trend will continue whilst hospital revenue continues to fall short of meeting capital costs of new equipment and buildings. Seven tables illustrate various financial trends, such as increase in construction costs and the general decrease in funds provided by the government and charitable organizations since the advent of Medicare in 1965. Medicare, and similar schemes such as Medicaid, provide for reimbursement to be made on a reasonable cost, non-profit making basis, but this appears to be inadequate in coping with depreciation reimbursement. The American Hospital Association's statement on the financial requirements of health care institutions analyses this situation and points out the inadequacy of historical cost-based depreciation reimbursement which is at present used and approved by the Social Security Administration. Present value depreciation reimbursement, which has yet to be adequately considered by the Social Security Administration, is shown to be more appropriate. Capital funds are urgently needed for hospital construction projects and this must be publicized. Training in hospital financial management should adequately cover these aspects of the service, and all hospital administrators should be aware of the current problems and try to find solutions.

SUPPLIES AND STORES

PURCHASING

See Abstract Nos. 939, 976

ECONOMIC USE OF SUPPLIES, DISPOSABLES

See Abstract No. 1012

CATERING, DIETETICS, KITCHENS

HOSPITAL CATERING

See also Abstract No. 925

976. **Example of a trend: food purchasing program, Chicago Hospital Council.** *Journal of the American Dietetic Association*, Chicago, 1975, Feb., vol. 66, no. 2, pp. 162-165.

The food purchasing programme of the Chicago Hospital Council is a specialized part of the Council's Group Purchasing Program, which is only one part of the shared services offered to member hospitals. This paper outlines the history of the programme and presents some comments from food buyers obtained in a postal questionnaire. Brief mention is made of other central food purchasing programmes.

977. HENLEY, M. M. **Microwave cooking—way of the future?** *Hospital Administration in Canada*, Don Mills, Ont., 1975, Feb., vol. 17, no. 2, pp. 42, 44.

This paper discusses the experience of introducing and implementing a microwave-based convenience food system at McMaster University Health Sciences Centre, Hamilton, Ont. The system followed is outlined and problems relating to food, equipment and staff are discussed. The problems are however outweighed by the advantages—the patient gets hot food of excellent quality, there is a minimum of waste, staff requirements are reduced, and, in general, the patient response to meals is favourable.

DIETETICS IN THE HOSPITAL

978. GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. **Nutrition and modified diets.** (Health Service Catering Manual, Vol. 1) London, Department of Health and Social Security, 1975, 100pp.

This publication is intended primarily for use in hospital catering departments and by hospital nursing staff. It is in four parts: (i) nutrition; (ii) nutrition applied to hospitals; (iii) menus; and (iv) modified diets. Examples of menus are given to demonstrate how the requirements of modified diets may be met from a general bill

of fare in both acute and long-stay hospitals. They are not intended as standard menus, as a substitute for local menu planning, or as a replacement for professional dietetic advice.

979. SJUKVÅRDENS OCH SOCIALVÅRDENS PLANERINGS- OCH RATIONALISERINGSINSTITUT. Sjukhuskost—näringsuträkning. **[Hospital diets—nutritional calculations.]** (Spri råd 6.14) Stockholm, Spri, 1974, 27pp.

This publication describes Prandium, Spri's computerized system for nutritional planning of hospital diets. In this system, meal components are assessed for quality by nutritional content per 100 kcal. and the size of portions is indicated by the energy factor. A test of the system at one hospital is described in an appendix. [This abstract has been prepared from an English summary of the publication.]

HOSPITAL DOMESTIC MANAGEMENT

980. MUELLER, F. **Staff involvement raises morale—reduces cost and turnover.** *Dimensions in Health Service*, Toronto, 1975, March, vol. 52, no. 3, pp. 41-42.

The staff suggestion scheme in the housekeeping and laundry departments at Tucson (Ariz.) Medical Center has enhanced staff morale and been partly responsible for reducing staff turnover which is now at a monthly rate of six per cent. Awards are both monetary and recognition by certificates and letters of appreciation. Four suggestions that have been submitted and implemented in the last year are described. Consideration is now being given to extending the scheme to the whole hospital staff.

981. NIXSON, C. **Management by objective.** *Hospital Housekeeping*, Los Angeles, 1975, Feb./March, vol. 4, no. 1, pp. 23-24.

Management by objectives has been in use in the housekeeping department at the Inter-Community Hospital, Covina, Calif., for 18 months and has proved its worth. A table sets out the nine objectives and the measure of their achievement during a single quarter. An example is also given of proposed tasks and estimated dates of their completion for a given quarter. Over the 18 months' period productive salaries rose by 8.6 per cent, productivity increased from 88.7 per cent to 94.1 per cent and quality increased from 82.4 per cent to 88.4 per cent. Management by objectives is now in use for maintenance, medical records and respiratory therapy.

HYGIENE IN THE HOSPITAL

982. KOREN, H. **Environmental health and safety.** New York & Oxford, Pergamon, 1974, xxii, 315pp.

This volume covers all aspects of environmental health and safety in hospitals. It has seven chapters: (i) the hospital; (ii) environmental services, including food hygiene, housekeeping, pest control, laundry, maintenance, sanitation, noise and refuse disposal; (iii) infection control; (iv) fire safety; (v) patient and staff safety; (vi) staff health service; and (vii) special techniques, including disinfection, isolation procedures, microbiological testing and sterilization.

HOSPITAL INFECTIONS

983. FAVERO, M. S. and others. **Microbial contamination of renal dialysis systems and associated health risks.** *Transactions of the American Society for Artificial Internal Organs*, Washington, 1974, vol. 20-A, pp. 175-183; discussion p. 188.

Sophisticated technological advances in renal dialysis systems have not yet eliminated problems of microbial contamination. Studies were carried out to obtain data on the comparative microbiological quality of fluids associated with the basic types of dialysis systems and to assess the health significance of high levels of microbial contamination in these fluids. There are several reasons why such contamination could constitute potential hazards to patients undergoing renal dialysis: (i) although intact bacterial cells are too large to pass through an intact dialysis membrane, they could be introduced directly into the patient's blood during major or minor blood leaks associated with the integrity of the membrane or membrane housing: (ii) certain types of Gram-negative bacteria will grow rapidly in dialysate, especially when it contains metabolic products dialysed from the patient's blood, and toxic products from the bacterial cells can pass through intact membranes; and (iii) drug-resistant factors may be transmitted among the various Gram-negative bacteria. There are five tables.

984. GEHIBACH, S. H. and others. **Recurrence of skin disease in a nursery: ineffectuality of hexachlorophene bathing.** *Pediatrics*, Evanston, Ill., 1975, March, vol. 55, no. 3, pp. 422-424.

An outbreak of streptococcal and staphylococcal skin disease was discovered in a full-term nursery after the discontinuation of bathing infants with hexachlorophane. The epidemic was only temporarily controlled by conventional means and recurred despite restoration of hexachlorophane bathing. Measures that decreased infants' exposure to visitors and hospital staff and enforcement of aseptic techniques in the nursery were more important than the use of hexachlorophane soap in achieving and maintaining control.

985. NAJEM, G. R. and others. **Clinical and microbiologic surveillance of neonatal staphylococcal disease: relationship to hexachlorophene whole-body bathing.** *American Journal of Diseases of Children*, Chicago, 1975, March, vol. 129, no. 3, pp. 297-302.

Neonatal staphylococcal disease occurred in the nurseries of a university hospital three weeks after discontinuation of routine, daily, whole-body bathing of newborn infants with hexachlorophane. Of 16 infants who had clinical manifestations within a two-week period, 11 cases were confirmed bacteriologically. Shortly after the onset of the outbreak, daily clinical and microbiological surveillance and control measures on all infants and staff were inaugurated. Clinical surveillance after the outbreak did not yield any new case. *Staphylococcus aureus* was highest (13 per cent per week) during the first three weeks of microbiological surveillance (when hexachlorophane was not used); this is lower than that reported in most previous studies. These findings indicate the importance of scrupulous hand washing before and after handling each infant and of enforcement of other basic nursery techniques.

986. GRIST, N. R. **Hepatitis in clinical laboratories: a three-year survey.** *Journal of Clinical Pathology*, London, 1975, April, vol. 28, no. 4, pp. 255-259.

Hepatitis was reported from five per cent of 244 British clinical laboratories in 1970, from seven per cent of 215 in 1971, and from two per cent of 337 in 1972. Some of the 36 laboratories reporting hepatitis tested specimens from haemodialysis, transplant and haemophilia units and carried out tests for 'Au-SH antigen'. The average attack rate for all groups of staff was 111 per 100,000 with higher rates for biochemists (268 for graduates and 204 for technicians) and medical haemotologists (258). No case was fatal and only 10 out of 41 had to be admitted to hospital. Fourteen had had contact with high-risk (haemodialysis) specimens but the most frequent suspected source was personal contact with jaundiced or Au-SH antigen positive persons. Laboratory accidents were suspect in only three cases.

987. STOLLE, W. Häufung von Ruhrerkrankungen in Einrichtungen zur Pflege von psychisch Kranken am Beispiel des Landeskrankenhauses Schleswig, Krankenhaus für Kinder- und Jugendpsychiatrie. **[Endemic dysentery in psychiatric institutions, exemplified by Schleswig Hospital for Child and Adolescent Psychiatry.]** *Das Öffentliche Gesundheitswesen*, Stuttgart, 1975, March, vol. 37, no. 3, pp. 145-155; summary in English p. 145.

During the years 1969 to 1973 there were 155 children positive for dysentery bacteria in the children's department (average occupancy, 740) of the Schleswig Psychiatric Hospital. Of these children, 28 were clinically ill and three showed the classical symptoms of dysentery. Of five nursing staff who were positive, three needed treatment. The various possible sources of infection (e.g., human contact, food, equipment, insect vectors) are discussed and among the proposals put forward to control infection are the following: thorough hygienic surveillance; reduction of patient density in wards; more isolation rooms; intensive continuing disinfection; use of disposable towels and soap dispensers; bacteriological examination of kitchen staff; control of cockroaches; and detailed infection records.

SOURCES OF INFECTION

988. KNITTLE, M. A., EITZMAN, D. V. and BAER, H. **Role of hand contamination of personnel in the epidemiology of gram-negative nosocomial infections.** *Journal of Pediatrics*, St. Louis, 1975, March, vol. 86, no. 3, pp. 433-437.

A high incidence of hospital infection and colonization caused by Gram-negative enteric organisms with R-factor mediated kanamycin resistance was observed in an intensive care nursery. The hands of staff were thought to be important vehicles for the transmission of the organisms. This study was undertaken to clarify the nature of hand contamination and to evaluate its role in the hospital transmission of Gram-negative bacteria. In sequential hand cultures contamination of hands was transient in some nurses, but active multiplication of the organisms occurred on the hands of others and in a few nurses a temporary carrier state appeared to exist. The results of the study suggest that the hands of hospital staff may serve not only as a passive vehicle in the transmission of Gram-negative bacteria, but also may constitute a reservoir of hospital organisms.

989. BARTZOKAS, C. A., HOLLEY, M. P. and SHARP, C. A. **Bacteria in flower vase water: incidence and significance in general ward practice.** *British Journal of Surgery*, Bristol, 1975, April, vol. 62, no. 4, pp. 295-297.

Culture of flower vase water from wards in David Lewis Northern Hospital, Liverpool, revealed large numbers of potentially pathogenic bacteria. The types of organisms isolated may reflect the particular ecology of this hospital as they differed in some ways from those reported in other studies. The incidence of wound infections during the period of study was low (5.2 per cent) despite the regular overgrowth of bacteria in flower vases. There did not appear to be any correlation between the types of bacteria isolated from flower water and those responsible for wound infections. The addition of hydrogen peroxide to flower vases proved a very effective antiseptic and is recommended for general use as a precautionary measure.

990. HINMAN, A. R. and others. **Outbreak of lymphocytic choriomeningitis virus infections in medical center personnel.** *American Journal of Epidemiology*, Baltimore, 1975, Feb., vol. 101, no. 2, pp. 103-110.

An outbreak of lymphocytic choriomeningitis virus infections occurred in 48 staff at the University of Rochester Medical Center, 31 in the radiotherapy area, 12 in the animal research facility and five in other areas. Epidemiological and virological studies indicated that the source of infection was Syrian hamsters which were used in tumour research. Infection occurred not only through direct contact with infected animals but also from mere presence in the room where the animals were held. This outbreak emphasizes the need for restricting access to animal quarters and for surveillance of hamsters and tumour cell lines and indicates the necessity of separating animal facilities from patient care areas.

PREVENTION AND CONTROL

See also Abstract Nos. 933, 985

991. DANGEL, P. Massnahmen zur Infektionsverhütung bei der Intensivbehandlung von Risiko-Neugeborenen. **[Measures for the prevention of infection during intensive therapy of the at-risk newborn.]** *Fortschritte der Medizin*, München, 1975, April 10, vol. 93, no. 11, pp. 539-541; summary in English, p. 541.

Of 153 premature and newborn infants treated in 1973 in the intensive care unit at the Zürich Children's Hospital, 46 died but only five of these deaths were the result of infections. The measures taken at the hospital to prevent infection are described. They include: thorough cleansing of incubators; no routine use of antibiotics; adequate precautions in the use of catheters; attention to the personal hygiene of doctors, nurses and parents; disinfection of apparatus, furniture and rooms; use of sterilized tracheal tubes for intubation; and daily bacteriological inspections of tracheal secretions.

992. LUTZ-DETTINGER, U. Theoretische Grundlagen und praktische Hinweise zur Anwendung von UV-Strahlen im Krankenhaus. **[Theoretical principles and practical indications for the use of ultraviolet radiation in hospitals.]** *Krankenhaus*, Stuttgart, 1975, March, vol. 67, no. 3, pp. 105-110.

A general account is presented of the theory and practice of ultraviolet radiation and of the part it can play in hospitals in the reduction of bacterial contamination.

It is concluded that the application of ultraviolet radiation in hospitals should not be overvalued: it can be useful as a supplementary measure in certain areas, especially where it is necessary to maintain a low level of bacterial contamination of the air.

HYGIENE IN THE OPERATING THEATRE

See Abstract No. 1011

AIR HYGIENE

See Abstract Nos. 992, 1011

DISPOSAL OF WASTE

993. COOK, G. K. **Solving the problem at Walsgrave hospital.** *Health and Social Service Journal*, London, 1975, April 19, vol. 85, no. 4435, pp. 874-875.

The original incinerator system at Walsgrave Hospital, Coventry, was installed in 1966 and was capable of dealing with 600 pounds of waste per hour. As the amount and types of waste increased, this system could not cope when the firing capacity had to be reduced because too much smoke was being produced. The local authority agreed to collect domestic waste, the separation of which presented no difficulty, but only once a week. To avoid having too many skips for storing this, it was decided to instal a Simon-Vicars Model 10 compactor with three containers; the equipment and its operation are described. Modifications were also made to the incinerator and have reduced the smoke problem. Possible future developments are outlined.

994. RUFFELL, D. W. **Central incinerator scheme.** *Health and Social Service Journal*, London, 1975, April 19, vol. 85, no. 4435, p. 873.

Following an examination of incineration and waste collection in the Newcastle hospital group, it was decided to have a central incinerator for the whole group. The Jenkins/Kasin incinerator was selected; this machine is batch-loading and uses no auxiliary fuel. The machine, its operations and the experiments still being carried out with it are described. It is dealing with all types of waste found in teaching hospitals. Waste is collected in a lorry with a capacity of eight cu.m., but the load is never packed to ensure a maximum load of seven cu.m. to match the incinerator. On the wards, waste is placed in colour-coded bags—normal household waste for local authority collection, fouled and known infected waste for the incinerator. An 'on-call' system exists for the collection of specials, such as infected laboratory animals. The incinerator operates seven days a week from 0800 to 1700. The scheme has resulted in considerable savings.

SAFETY MEASURES

See also Abstract No. 982

995. MORSE, G. P. and MORSE, R. F. **Protecting the health care facility: a system of loss prevention management effective for all industry.** Baltimore, Williams & Wilkins, 1974, xviii, 318pp. £7.00

The prevention of loss, from whatever source, that threatens people, property and

health care programmes should be high in the administrator's priorities and responsibilities. This volume is in two parts: (i) concept of and philosophy of protection; and (ii) implementing the concept through systems design for protection. The functions covered include accident prevention, fire prevention, radiation safety, asset protection and staff protection.

ELECTRICAL ACCIDENTS

996. MONK, I. B. and SHAW, A. **Medical equipment hazards—practical experience in a large region.** *Biomedical Engineering*, London, 1975, April, vol. 10, no. 4, pp. 132-135, 140.

The West of Scotland Health Boards' Department of Clinical Physics and Bio-Engineering provides services to hospitals with a total of 36,700 beds. This paper reports on accidents involving patient interfaced medical equipment investigated by the department between October 1971 and October 1974. In a high proportion of accidents the cause was faulty design or poor construction of equipment, but a considerable number could be attributed to lack of user appreciation of the hazards involved. A few accidents were caused by inexperienced staff attempting to service equipment about which they knew little. A table lists the major incidents reported. Thirty-four per cent of faults were electrical and 53 per cent of incidents occurred in operating theatres.

997. PARKER, B. and RITTERMAN, S. A. **An inspection procedure for hospital room electrical systems.** *Medical Instrumentation*, Arlington, Va., 1975, March/April, vol. 9, no. 2, pp. 108-111.

Attention to relatively simple details greatly reduces electrical hazards in hospitals. This paper presents an effective test procedure for routine inspection of electrical systems and appliances in patient care areas. The test protocol was developed over a period of four years of routine inspection in a 1,300-bed hospital.

998. PFEIFFER, E. A. **A simulator for teaching electrical safety procedures in the hospital.** *Medical Instrumentation*, Arlington, Va., 1975, March/April, vol. 9, no. 2, pp. 103-105.

The most important step in reducing the dangers of accidental electrocution is the proper training of hospital staff in appropriate safety procedures. This paper describes a simulator developed as an aid for the training of Veterans Administration staff. Three typical demonstrations with the simulator are described.

FIRES AND FIRE PREVENTION

999. FLETCHER, S. and EALES, J. **Patient evacuation in a small unit.** *Dimensions in Health Service*, Toronto, 1975, March, vol. 52, no. 3, pp. 38-39.

Pouce Coupe (B.C.) Community Hospital is a 54-bed long-stay unit. In an emergency the hospital must be prepared to wait at least 20 minutes before outside assistance

comes. As an aid to evacuation, every bed is equipped with an under-mattress canvas sling, which means that, at an instant, every mattress becomes a stretcher for evacuation. The method used is described with the aid of a diagram and five photographs.

THE PATIENT

WELFARE OF THE PATIENT

See Abstract Nos. 1000, 1024, 1045, 1054

VOLUNTARY SERVICE, VOLUNTARY WORKERS

See Abstract Nos. 1059, 1062-1063

THE GENERAL PRACTITIONER AND HIS PATIENTS

See Abstract No. 1041

TRANSPORT OF PATIENTS

See Abstract No. 1029

HOSPITAL CARE

See also Abstract Nos. 1036, 1037, 1060

1000. BIRATH, G. Har vi råd med personlig sjukvård? **[Can we provide personalized hospital care?]** *Sjukhuset*, Göteborg, 1975, vol. 52, no. 3, pp. 117-118, 120.

Patients' contact with treatment 'teams' in hospital is of very short duration, and no-one regards any particular patient as his 'own'. The modern hospital environment is inimical to the establishment of personal relationships, and a pessimistic view foresees a future in which individual human relationships with patients will have dwindled to nil. Patients have the right to a consultation with the doctor on admission: there ought to be time for another, informative consultation on discharge. Members of the nursing staff should also take time to give patients information, particularly about any interventions or tests involving discomfort. Staff of all categories should take especial time to comfort the dying: death is very difficult to accept in the materialistic society. In order to improve the situation and counteract the modern trend towards depersonalization of hospital care, we must not only train ourselves to become good technicians, expert in the use of the facilities the technological revolution has placed at our disposal, but also to meet our patients as human beings.

1001. COLLINGWOOD, M. P. **The nursing care plan as a basis for an information system based upon individualised patient care.** *Nursing Times*, London, 1975, March 20, vol. 71, no. 12, occasional papers pp. 21-22; March 27, vol. 71, no. 13, occasional papers pp. 25-28.

This paper describes a model of a nursing care plan which has been devised in the North Lothian Group of hospitals and is now in use throughout the general wards in the group. It is in the form of a card which supplements the existing Kardex. The card, an example of which is reproduced, is divided into sections to cover the main areas of care: basic care and personal hygiene; diet; mobilization; technical care; observations; treatment by medical staff and/or investigations; special needs—psychological support; and future plans. The second part of the paper describes how the data collected can be used as a basis for an information system for several purposes, particularly for calculating the number of nursing staff needed.

1002. MOORE, G. T. and others. **Comparison of television and telephone for remote medical consultation.** *New England Journal of Medicine*, Boston, Mass., 1975, April 3, vol. 292, no. 14, pp. 729-732.

In Cambridge, Mass., nurse practitioners in neighbourhood health centres provided primary care with support from medical staff at Cambridge Hospital. Before the start of the study reported here the nurse practitioners received their backup by telephone, with either an immediate or a delayed referral to the physician when telephone communication was not sufficient. During the study three centres were equipped with microwave television connecting to a central, television-equipped room in the out-patient department of the Cambridge Hospital. Visits using television for consultation averaged 50 minutes as compared with 40 minutes for telephone. However, television consultations resulted in significantly fewer immediate referrals of patients to hospital physicians. Although no overall difference in satisfaction was documented, participants preferred television for medical decision-making and cited it for allowing more social interaction than telephone.

1003. FELTON, G. **Increasing the quality of nursing care by introducing the concept of primary nursing: a model project.** *Nursing Research*, New York, 1975, Jan./Feb., vol. 24, no. 1, pp. 27-32.

At the Children's Hospital National Medical Center, Washington, D.C., a comparison was made of nursing performance under two systems: (i) primary nursing, where six to eight patients (and their families) are assigned to one nurse who is responsible for planning, implementing, evaluating and co-ordinating nursing care until discharge; and (ii) group care, where a registered nurse leads a team who look after 10 to 12 patients. Performance as measured by three scales (Slater Nursing Competencies, Quality Patient Care, and the Phaneuf Nursing Audit) was higher on the primary nursing unit.

1004. GORAN, M. J. and others. **The PSRO hospital review system.** *Medical Care*, Philadelphia, 1975, April, vol. 13, no. 4, supplement pp. 1-33.

This paper defines the Professional Standards Review Organization (PSRO) hospital review system, describes how the three major components (concurrent

review, medical care evaluation studies, and profile analysis) interrelate and provides examples of each of these components. Under utilization review requirements or PSRO, hospitals will be required to implement an integrated system of review designed to assure appropriate utilization practices and improve the quality of care. These aims are to be accomplished through: the application of concepts of peer review; the use of norms, criteria, and standards; the identification of deficiencies in the quality, administration and appropriateness of health care services; and their correction through linkage with programmes of continuing medical education. Although PSROs are initially responsible for review in hospitals, they will likely provide the locus for a community-wide system of peer review for all services provided under national health insurance.

1005. JESSEE, W. F. and others. **PSRO: an educational force for improving quality of care.** *New England Journal of Medicine*, Boston, Mass., 1975, March 27, vol. 292, no. 13, pp. 668-671.

The major purpose of the Professional Standards Review Organization (PSRO) programme is to improve the quality of patient care. Peer review is expected not only to detect problems but to analyse causes, and to develop, implement and evaluate corrective programmes. Such peer review efforts are in themselves educational. In addition, educational programmes focusing on identified deficiencies must be organized to involve individuals or groups. Integration of local PSRO review activities with the educational programmes of local health facilities and organizations of all types is urged. Although PSROs will not specifically underwrite continuing health care education, they should provide a community-wide means for integrating patient care review with continuing medical education.

1006. MCKILLOP, W. **Assessing quality of medical care.** *Hospital Administration*, Chicago, 1974, vol. 19, no. 4, pp. 20-43.

This paper examines the concepts and methods of medical care evaluation and reviews the present state of the art and possible future developments. A number of questions are being asked about professional standards review organization developments; these are not easily resolved but some constructive suggestions are made. The paper includes a list of 67 references to the literature.

1007. NELSON, A. R. **Relation between quality assessment and utilization review in a functioning PSRO.** *New England Journal of Medicine*, Boston, Mass., 1975, March 27, vol. 292, no. 13, pp. 671-675.

The Utah State Medical Association, through its peer review foundation—the Utah Professional Review Organization, has implemented an integrated system of utilization review and quality assessment linked to a programme of continuing education. Nurse co-ordinators, employed by the Organization, screen all hospital in-patients covered by Titles XVIII, XIX, and V as well as by subscribing private insurers. Approximately 10 per cent of hospital patients do not meet peer-generated criteria for admission review or length of stay and are screened out for peer review. The nurse co-ordinators collect data for retrospective quality assessment, identifying targets for continuing medical education. Preliminary data support the cost effectiveness of such a review programme. Continuing quality audit will test the effectiveness of educational programmes.

1008. HOLLOWAY, D. C., WICZAI, L. J. and CARLSON, E. T. **Evaluating an information system for medical care evaluation studies.** *Medical Care*, Philadelphia, 1975, April, vol. 13, no. 4, pp. 329-340.

One computerized information system, the Professional Activity Study-Medical Audit Program (PAS-MAP), is available in the United States for purposes of supporting medical care evaluation studies. This service is provided by the Commission on Professional and Hospital Activities (CPHA). In order to determine its effectiveness in assisting medical care evaluation studies, PAS-MAP was compared with a manual system for collecting data not contained on the face sheet of medical records. The results indicated that, compared with the manual system, PAS-MAP was: less costly if more than 41 per cent of hospital patients were included in medical care evaluation studies; as timely as the manual system for data it could provide but provided fewer clinical data elements than physicians requested; and less protective against human error. Three decision makers assigned weights indicating the relative importance of these results. The weights were combined in an additive model to arrive at a score for each system. Based on these scores the manual system was recommended for implementation.

DISCHARGE OF PATIENTS

See Abstract No. 1061

HOME CARE, AFTER-CARE

See Abstract Nos. 1062, 1063

SPECIAL DEPARTMENTS

ADMINISTRATIVE OFFICES

See Abstract No. 926

WARDS

See also Abstract No. 1022

1009. **One patient, one room: theory and practice.** *Modern Healthcare*, Chicago, 1975, March, vol. 3, no. 3, pp. 65-68.

This paper reports a study by a firm of architects of single and multiple rooms in four hospitals with 300 to 400 beds in California and Utah. The report covers: length of stay, quality of care, ambulation, isolation, categories of patients, visiting, shower use, medication errors, emergencies, layouts and views, staffing, nurses' calls, transfers, reimbursement and charges, and costs. The choice of single or multiple rooms is clearly for the individual hospital to decide. Opinion in the survey was unanimous that quality of care was significantly better in single rooms. Opinion on the need for

at least some multiple occupancy rooms for specialties such as ophthalmology and orthopaedics was divided. The decision to build single rooms would add approximately $2.50 to $3.10 per square foot to the cost of a 300-bed hospital originally designed with more conventional nursing units divided 80 per cent to 20 per cent between double and single rooms.

OPERATING SUITES

See also Abstract No. 936

1010. BROCK, Lord. **The importance of environmental conditions, especially temperature, in the operating room and intensive care ward.** *British Journal of Surgery*, Bristol, 1975, April, vol. 62, no. 4, pp. 253-258.

The climatic conditions necessary in the operating theatre to give an optimal environment are discussed. These are second in importance only to control of infectivity. Air-conditioning in operating suites should be obligatory. The temperature most favoured by surgeons is 18.5° to 21°C; some prefer a range of 21° to 22°C. The critical ambient temperature desirable is 21°C; for infants and children this may be increased to 24°C. It is difficult or impossible to achieve climatic conditions in the operating theatre that are acceptable to all. The needs of the patient are of special importance and are largely neglected; he alone is unable to speak for himself. The disposition of air inlets in the theatre is fully discussed. Climatic conditions in the intensive care unit are also of great importance. The need for full air-conditioning is absolute although this is often ignored. The delivery of conditioned air within the intensive care unit is fully presented, especially the need to avoid direct chilling of the patient. The advantages of horizontal laminar air flow are outlined.

1011. HUTTON, P. and THOMPSON, J. M. **An anemometer for air flow studies in operating theatres.** *Engineering in Medicine*, London, 1975, Jan., vol. 4, no. 1, pp. 11-16.

Considerable concern has been expressed about the levels of various anaesthetic vapours and gases present in operating theatre atmospheres and the possible correlation of these with certain conditions occurring in theatre staff. Investigations of theatre air pollution have been inadequate through lack of accuracy in measuring air flow. This paper describes the construction of an inexpensive new type of tubular hot wire probe and calibration system which, whilst being suitable for measuring theatre air currents, can be interfaced with most types of constant temperature anemometer bridge commercially available. It has been used to plot ventilation patterns in operating theatres and has demonstrated the contribution of natural convection if a large area of single glazing is present.

1012. BELKIN, N. L. **Operating room: the rationale for re-usables: the other side of the drape.** *Hospital Topics*, Chicago, 1975, Jan./Feb., vol. 53, no. 1, pp. 45-48, 50-51.

The pros and cons of disposables and re-usables are considered with special reference to surgical gowns and drapes. After defining the terms disposable and re-usuable the author considers the purpose of gowns and drapes, the relationship

between asepsis and the over-all environment, and the value of lightly woven textiles in reducing the spread of bacteria, especially in the sterile field. Most hospitals find the cost of disposables generally higher than that of re-usables because labour cost cannot be cut in proportion to work reduction. More storage space is needed for disposables and there is the threat of contamination of the hospital environment from the handling of solid waste generated by them. The author concludes that as long as re-usables are readily available at reasonable cost, as they are now, there is every justification for their continued use. Fifty references to the literature are given.

PHARMACY

1013. AMERICAN SOCIETY OF HOSPITAL PHARMACISTS. **Accreditation standard for pharmacy residency in a hospital, with guide to interpretation.** *American Journal of Hospital Pharmacy*, Washington, 1975, Feb., vol. 32, no. 2, pp. 192-198.

The document reproduced in this paper sets out the standards approved by the American Society of Hospital Pharmacists for the accreditation of 'residency' post-graduate training of pharmacists in hospitals; this training aims to develop special skills and competency in hospital pharmacy beyond the legal requirements for licensure. There are six standards as follows: qualifications of the training hospital; qualifications of the pharmacy service; qualifications of the preceptor (the pharmacist-in-charge of the hospital service); qualifications and selection of the applicant; residency training schedule; and certification.

1014. KNIGHT, J. R. and CONRAD, W. F. **Review of computer applications in hospital pharmacy practice.** *American Journal of Hospital Pharmacy*, Washington, 1975, Feb., vol. 32, no. 2, pp. 165-173.

This is a comprehensive review of the literature from 1961 to 1974 (with 111 references) on the use of computers in the practice of hospital pharmacy. The subject is dealt with under the following heads: accounting and drug use review; purchasing and inventory control; controlled substances; out-patient services; drug distribution; drug information; and clinical services.

1015. DENBO, R. D. and KARAM, J. A. **Evolution of a clinical pharmacy service and drug information center in a non-profit community hospital.** *Hospital Topics*, Chicago, 1975, Jan./Feb., vol. 53, no. 1, pp. 24, 29.

As a first step towards a full clinical pharmacy programme at the 442-bed St. Vincent Charity Hospital, Cleveland, Ohio, a clinical pharmacy service was established for the intensive care unit and the neurosurgical units. The service operates eight hours a day, Monday to Friday, and a satellite pharmacy on the nursing floor functions at week-ends. When the satellite is closed drugs come from the central pharmacy. The clinical pharmacist is supported by a drug information centre which will serve the whole hospital. Initially the idea was presented to the doctors responsible for the nursing units and weekly meetings were held for the nursing staff to acquaint them with the project. Pharmacists and technicians also had to be educated as to the new clinical role of the satellite pharmacy. In this paper the procedure for the drug distribution system on the satellite pharmacy and the duties of a clinical pharmacist

and a pharmacy technician are set out in some detail. It is hoped that the results of the project will prove to the administrators and the nursing staff that relieving nurses of pharmacy related activities will lead to more efficient patient care.

1016. MOIR, D. C. and others. **A hospital based drug information system.** *Health Bulletin*, Edinburgh, 1975, March, vol. 33, no. 2, pp. 82-88.

This paper describes a study of the problems of assessing the clinical importance of adverse reactions to drugs by following up the suspicions raised by voluntary reporting schemes in the more controlled conditions of the hospital environment. It is based on a drug information system, described in detail, which by 1968 handled 500 records and 4,000 punch cards weekly and was later written to store, analyse and retrieve the information on an ICL 4/50 computer. The system permits rapid identification of the total population who have received a suspect drug in hospital. It also identifies patients receiving two or more drugs in combination thus facilitating studies of drug-drug interactions.

1017. GIBSON, J. T. and ALEXANDER, V. L. **Adherence to approved drug use as a predictor of length of hospital stay.** *American Journal of Hospital Pharmacy*, Washington, 1975, March, vol. 32, no. 3, pp. 280-282.

The records of 200 patients at a 175-bed short-stay paediatric hospital were reviewed to determine if the actual drug therapy agreed with the officially approved indications, contraindications, age restrictions and dosages. The average length of stay was nine days. Only 19 per cent of the observed variation in length of stay could be correlated to the number of doses per drug per patient. The variable dose, indications, contraindications, and age agreement could not be correlated to length of stay.

1018. MEANS, B. J., DEREWICZ, H. J. and LAMY, P. P. **Medication errors in a multidose and a computer-based unit dose drug distribution system.** *American Journal of Hospital Pharmacy*, Washington, 1975, Feb., vol. 32, no. 2, pp. 186-191.

The Johns Hopkins Hospital, Baltimore, uses two drug distribution systems: a conventional multidose and a computer-based unit dose system. The medication errors under the two systems were compared over a 60-day period in two similar medical ward units using the different systems. In 1,428 observations in the multidose unit there were 105 errors (7.35 per cent); with the computer-based unit dose system there were 20 errors in 1,243 observations (1.61 per unit). The probable cause of the medication errors under the unit dose system was determined in 15 of the 20 unit dose cases: in only one was the error due to the system itself, the others being attributable to human causes. Tables show the errors classified by type and by dosage form, and the probable causes and point of occurrence of errors. Diagrams show the work flow of the two systems.

1019. SCHNELL, B. R. and others. **Unit-dose in an 85-bed hospital.** *Canadian Journal of Hospital Pharmacy*, Saskatoon, 1975, Jan./Feb., vol. 28, no. 1, pp. 21-24.

The Canadian Society of Hospital Pharmacists is carrying out a study of unit dose drug distribution in one hospital in each of four categories: under 100 beds, 100 to 250 beds, 251 to 500 beds and over 500 beds. This is the first of a series of papers

describing the system developed in each of the hospitals and deals with the 85-bed St. Elizabeth's Hospital, Humboldt, Sask. A description of the hospital's former traditional drug distribution system is followed by an account of the design and implementation of the new unit dose system. It is concluded that unit dose drug distribution in small hospitals is definitely possible. It appears that the generally accepted advantages can be realized, even within the constraints of a one-pharmacist operation.

1020. DENNIS, I. **The design and experimental testing of a hospital drug labelling system.** *Programmed Learning & Educational Technology*, London, 1975, March, vol. 12, no. 2, pp. 88-94.

An investigation of the labelling of hospital pharmaceutical preparations was undertaken by the University of Reading Typography Unit at the invitation of the pharmacy department of the London Hospital. A questionnaire was sent to hospital pharmacies in England, Scotland and Wales and the samples collected as a result indicated a low standard in terms of design, materials and printing. There was an absence of standardization as regards terminology, typography and label formats which makes for inefficiency and could be dangerous. The London Hospital was asked to supply full details of their labelling requirements in terms of bottle sizes and wording and to rank the information for each class of labels in order of importance. A full list of design objectives was then agreed. Labels for mixtures presented most problems and detailed design work for these was begun. The redesigned labels were then compared for effectiveness with labels drawn from hospital stocks. Three sets of 22 labels were used: (i) the redesigned ones; (ii) existing London Hospital labels; and (iii) St. Bartholomew's Hospital labels. Student nurses from the two hospitals, as well matched as possible as regards eyesight, time on duty, etc., were used in the experiment. It was found that the origin of the label significantly affected its selection time. Subjective comments by nurses revealed a marked preference for the proposed new style but some London Hospital nurses preferred their existing labels.

1021. NATIONAL COORDINATING COMMITTEE ON LARGE VOLUME PARENTERALS. **Recommended methods for compounding intravenous admixtures in hospitals.** *American Journal of Hospital Pharmacy*, Washington, 1975, March, vol. 32, no. 3, pp. 261-270.

Recommendations are presented on: (i) hospital receipt and storage of large volume parenterals; and (ii) hospital compounding of intravenous admixtures. The recommendations are presented step-by-step and cover: receiving and storage; compounding; transport to patient care area; compounding in the patient care area; and administration. A self-evaluation form is included, together with an illustration of a suggested dressing change for an intravenous catheter.

1022. JEFFREY, L. P., TEMKIN, L.A. and KRUGMAN, M. E. **Assuring the quality of medications stored in patient care areas.** *American Journal of Hospital Pharmacy*, Washington, 1975, March, vol. 32, no. 3, pp. 283-285.

This paper describes a programme designed to improve patient care by assuring the quality of medications stored in patient care areas. It is based on a questionnaire covering six major areas: medication room, controlled substances, refrigerator,

emergency medication kit, other storage areas, and miscellaneous. The questionnaire is designed to assist in gathering information during medication quality assurance rounds. Rounds are conducted every four months by a pharmacist and a nurse. To ensure that any deficiencies are corrected, copies of the findings are sent to the appropriate pharmacy and nursing staff. The questionnaire is reproduced. It is believed that this programme is an effective one.

LABORATORIES

See also Abstract Nos. 927, 986

1023. BERGQVIST, F. and BENGTSSON, S. **The BACTLAB system—a data system for bacteriological routine.** *Computer Programs in Biomedicine*, Amsterdam, 1975, March, vol. 4, no. 3, pp. 144-157.

The BACTLAB system was developed for the Institute of Clinical Bacteriology, Uppsala University, using an IBM 1130 computer equipped with an IBM 1231 optical reader. In the spring of 1974 it became necessary, for administrative reasons, to transfer the data work to an IBM 370/155 computer and at the same time the old data system was revised and improved in several ways. This paper describes the revised version. The system uses punch cards to capture all administrative data and optical mark recognition documents for the bacteriological findings. The output includes reports for the customers and report lists for the laboratory, as well as surveys of findings of pertinent bacteria produced twice each month. In addition, bills are produced at regular intervals, both for hospitals and for private patients. All results are stored on magnetic tape in order to make later analysis possible.

REHABILITATION

See Abstract No. 1051

DEPARTMENTS FOR SPECIAL THERAPY

See also Abstract Nos. 930, 983

1024. LAUGHARNE, E. **The tri-hospital/diabetes education centre.** *Dimensions in Health Service*, Toronto, 1975, March, vol. 52, no. 3, pp. 43-44.

Three of Toronto's teaching hospitals, Toronto General, Mount Sinai and Women's College Hospital, have brought together their health services to provide a diabetes education centre which is physically located at Women's College Hospital. The objective of the centre is to teach each diabetic everything he is capable of learning about his condition and its treatment. The centre's staff includes physicians, nurses, social workers and dietitians. Their roles are described. It is estimated that the centre, which is financed by the Ontario Ministry of Health, has saved the province at least $100,000 in in-patient costs. [A description of this centre also appears in: *Hospital Administration in Canada*, Don Mills, Ont., 1975, April, vol. 17, no. 4, pp. 28-30, 32.]

1025. SALTER, R. H. and others. **Patient-oriented gastroenterology.** *British Medical Journal*, London, 1975, April 19, vol. ii, pp. 130-131.

At the beginning of 1973 the Cumberland Infirmary, Carlisle, launched a combined consultative out-patient clinic for gastro-enterology problems, with contributions from physician, surgeon, radiologist and pathologist. This paper outlines the procedure followed, discusses some organizational problems and analyses the first year's work. It is shown that the major benefit was improved patient management: hospital attendances were reduced, the diagnostic process was accelerated, and unnecessary radiological investigations and surgical operations were avoided. There were no obvious major disadvantages.

1026. VANCE, J. C. **Day-transfusion centre for patients with thalassaemia major.** *Lancet*, London, 1975, April 26, vol. i, pp. 967-968.

In August 1973 the Royal Children's Hospital, Melbourne, Australia, established a day transfusion centre for the treatment of children with thalassaemia major. The centre is in the medical out-patient department and is managed by a nursing sister trained in the technique of venepuncture. Up to four patients can be treated on any one day. The results of the first four months of operation are compared with a similar period before the centre opened, for the same 50 children. There were significant decreases in the number of nights spent in hospital, hours spent at hospital for each transfusion, days lost from school or usual activity and travel costs.

INTENSIVE CARE UNITS

See also Abstract Nos. 988, 991, 1010, 1054

1027. POLISH HOSPITAL ASSOCIATION. Pamietnik IV Zjazdu Naukowego, Warszawa, 15-16 Marca 1974r. Cześć II. **[Proceedings of the 4th Scientific Meeting, Warsaw, 15-16 March 1974. Part II.]** *Szpitalnictwo Polskie*, Warszawa, 1974, vol. 18, no. 6, pp. 333-436.

These proceedings include 29 papers on organizational, clinical and general problems of intensive care units, most with summaries in English and Russian.

1028. CRAMPTON, R. S. and others. **Reduction of prehospital, ambulance and community coronary death rates by the community-wide emergency cardiac care system.** *American Journal of Medicine*, New York, 1975, Feb., vol. 58, no. 2, pp. 151-165.

The Charlottesville-Albemarle, Va., area emergency cardiac care system comprises a mobile pre-hospital unit, an in-hospital mobile coronary care unit, progressive intermediate coronary convalescent unit and the hospital coronary care unit (HCCU). Telephone requests from doctors, emergency medical technicians and the public activate the emergency system, and an ambulance containing portable emergency cardiac care equipment and the care team is sent immediately. Since the establishment of the pre-hospital unit, coronary deaths during ambulance transport have fallen by 62 per cent and pre-hospital coronary deaths in general by 26 per cent in patients under 70 years of age. Two-thirds of patients with acute myocardial infarction had

long-term survival after receiving pre-hospital resuscitation, and most of such patients were admitted to the HCCU within one hour. The quick and effective pre-hospital treatment enabled patients to be released from the HCCU more quickly, in some cases after 48 hours. Pre-hospital treatment has thus proved economic and effective, requiring few extra hospital staff, and resulting in a total systems approach to the problem of coronary care when combined with an effective HCCU. A list of 95 references to the literature is included.

1029. FREEMAN, J. W. and LOUGHHEAD, M. G. **A coronary care ambulance controlled by radio telemetry.** *Medical Journal of Australia*, Sydney, 1975, Feb. 1, vol. i, no. 5, pp. 132-134.

This paper describes a coronary care ambulance service based on a radio telemetry system which allows a doctor in a remote coronary care unit to monitor a patient and give instructions on treatment to trained ambulance officers. The ambulance officer is required to carry out only two forms of treatment, defibrillation and giving an intravenous injection, and then only when instructed. The ambulance could be called by the public as well as doctors; two-thirds of calls were from the public. During a 12-month period, 320 calls were received; 33 per cent of the calls from both groups were for acute myocardial infarction, but 78 per cent of the calls from doctors were for heart disease compared with 60 per cent from the public. The mean duration of monitoring from the time radio contact was established with the ambulance until arrival at the coronary care unit was 25 minutes, and 40 per cent of the patients showed arrhythmias in this time.

SPECIAL HOSPITALS AND UNITS

OUT-PATIENT

See also Abstract Nos. 1002, 1025, 1053

1030. ROEMER, M. I. **From poor beginnings, the growth of primary care.** *Hospitals*, Chicago, 1975, March 1, vol. 49, no. 5, pp. 38-43.

A brief account is given of the development in the United States of health services for ambulant patients from the dispensaries of the 18th century to the health clinics of the 20th. Today there are seven main types of 'organized ambulatory services' as follows: clinics of public health agencies, of which there are about 1,700, mainly concerned with prevention; industrial health units; school health services; private group medical practice; special governmental programmes, for special population groups or selected diseases; special voluntary programmes; and hospital out-patient departments which now account for 18 per cent of physician/ambulant patient consultations of which there are about five per person/year in the United States.

1031. MEYERS, D. and CUGLIANI, A. **Who needs ambulatory care?** *Hospitals*, Chicago, 1975, March 1, vol. 49, no. 5, pp. 51-54.

In June 1974 Blue Cross and Blue Shield of Greater New York carried out a survey of out-patient and casualty department patients at 135 hospitals: a total of 16,822

patient visits (73 per cent out-patient and 23 per cent casualty) were reported on over a three-week period. Results show that 84 per cent of out-patient visits were by appointment: clinics for general medicine, paediatrics, eye diseases, obstetrics, general surgery and allergy were busiest. Nearly two-fifths of visits resulted from self-referral and three-quarters were asked to return. Of the 4,437 visits to casualty departments 44 per cent were the results of accidents, poisoning or violence. Almost 60 per cent received no laboratory or X-ray service and 30 per cent were referred to a clinic or agency or admitted as in-patients. Details are given of the race, income and age and sex distribution of patients.

1032. KATZ, G. and HOLLANDER, F. L. **From clinic to group practice.** *Hospitals*, Chicago, 1975, March 1, vol. 49, no. 5, pp. 67-71.

In January 1972 the 250-bed Samuel H. Daroff Community Hospital, situated in a low-income district of South Philadelphia, completely reorganized its services for out-patients. The new organization, called the South Philadelphia Medical Group (SPMG) is based on a private practice model and has four sections: medicine, paediatrics, obstetrics and gynaecology, and surgery. Doctors work either full-time with a guaranteed annual income plus an incentive percentage or they get 75 per cent of fees collected on their behalf with the remaining 25 per cent retained by SPMG. Services are now provided for all income groups (previously only the indigent had been treated) and the scope of services, and the demand for them, has increased rapidly. In October 1974 there were 3,100 visits compared with 1,100 in the final months of the old system. There is now a staff of 32 doctors who cover every major specialty. SPMG makes use of the hospital's ancillary services.

1033. BLANJAAR, J. A. and WEEBER, A. J. De afspraakregeling in de polikliniek van een ziekenhuis. **[Appointment systems in hospital out-patient departments.]** *Ziekenhuis*, Utrecht, 1975, April 2, vol. 5, no. 7, pp. 164-169.

Patients' visits to polyclinics are of two types: visits to consult a specialist and visits for examination or treatment by medical or paramedical staff. The aim of appointment systems in the first category is to reduce the patients' waiting time. Appointment systems for the second type of visit aim not only at reducing patients' waiting time but also at making the most efficient use of services. A number of different appointment systems are outlined. In order to ensure that patients can take advantage of as many services as possible during a single visit to the polyclinic it is advisable for all appointments to be made through a central appointments office. The measures put forward in this paper are intended as a model for future use.

1034. HERR, C. E. A. and PATRIKAS, E. O. **Keeping track of ambulatory care.** *Hospitals*, Chicago, 1975, March 1, vol. 49, no. 5, pp. 89-92.

The increasing development of out-patient services in the United States makes it important that medical records in this field should be properly maintained. This has recently been recognized by the Joint Commission on Accreditation of Hospitals which now includes in its *Manual* a standard requiring adequate out-patient records. It is calculated that a population of 10,000 will generate 50,000 out-patient visits annually, requiring 150,000 items of record creation, storage and/or retrieval. This requires two clerks per 10,000 population. The various record systems recommended are described.

1035. VALLBONA, C. and others. **Computer support of medical decisions in ambulatory care.** *Methods of Information in Medicine*, Stuttgart, 1975, April, vol. 14, no. 2, pp. 55-62.

The main purposes of this report are: (i) to identify the critical points of decision making in the ambulatory care process; (ii) to discuss current computer applications aimed at assisting health professionals in making proper and rapid decisions; and (iii) to present experience with a specific computer application in a neighbourhood clinic. Applications discussed include triage, automated history, multiphasic screening, algorithms for the management of specific problems, laboratory testing, medical record data bases, treatment selection, drug interaction and quality of care review. The Department of Community Medicine, Baylor College of Medicine, Houston, Tex., is using two modules of computer support in a neighbourhood clinic: the health-illness profile and analysis of administrative statistics. These are described and examples of the printout are reproduced.

1036. PHILLIPS, D. F. **Protocols for patient care.** *Hospitals*, Chicago, 1975, March 1, vol. 49, no. 5, pp. 85-88.

The acceptance of non-medical staff (e.g. physicians' assistants, nurse practitioners, health aides and health assistants) to supplement the shortage of doctors in out-patient services has met with some opposition. One method of solving this problem is the use of clinical algorithms, instruments which describe the appropriate, step-by-step procedures to be taken in solving or managing a specific clinical problem. These algorithms help in defining the skills needed, in training non-medical assistants, and in supervising them in their work. Examples are given of medical services where clinical algorithm systems are in use.

1037. SANDLOW, L. J. **Quality for walking patients.** *Hospitals*, Chicago, 1975, March 1, vol. 49, no. 5, pp. 95-99.

The standards laid down for the United States by the Joint Commission on Accreditation of Hospitals require the same quality of care for out-patients as for in-patients. The procedures adopted at Michael Reese Hospital and Medical Center, Chicago, for evaluating out-patient care are described under five heads: selection of problems; criteria development (including data base criteria, criteria defining minimum and maximum periods for statement of the problem, criteria for plans, and criteria for progress notes); measuring performance; audit committee evaluation; and feedback. Other aspects of the subject dealt with are organizational structure, utilization review, the health problem index, and the clinical management system.

CASUALTY AND ACCIDENT

See also Abstract No. 1031

1038. BUSH, P. **The organization of a city accident centre.** *National Hospital*, Chippendale, N.S.W., 1975, Jan./Feb., vol. 19, no. 1, pp. 29-30.

Accident centres are best sited within a major hospital and should be quite separate from casualty departments. They should be designed to allow a free flow of patients

through the stages of resuscitation, stabilization and preliminary treatment. Facilities which must be immediately on hand include resuscitation, catheterization, cardiac monitoring, control of haemorrhage and dressing of major wounds. X-rays and operating theatres should be close at hand. Medical and nursing staff should be senior and experienced and must work as a team. There should be a director (a doctor) and the department should be organized in four stages: reception, stabilization, definitive treatment, and admission. An important function of the unit is the sorting of patients into urgent and non-urgent categories.

1039. MASON, A. A. **Accident records on computer.** *Health and Social Service Journal*, London, 1975, March 29, vol. 85, no. 4432, pp. 708-709.

This paper describes the development of a computerized accident records system at Frenchay Hospital, Bristol. It is based on a two-part set, A4 in size, thin paper with NCR backing for the top sheet and stiff card for the accident record. The card is completed in part by the clerk or nurse at the reception desk, medical staff enter diagnostic codes, etc. and remaining details, according to disposal, are added on its return to the reception desk. On completion of treatment the top sheet is detached and filed for despatch weekly to the computer department. A copy of the accident record is reproduced.

1040. LUSK, E. J., NOVAK, A. G. and ROUX, R. G. **Emergency service—how do you measure its financial impact?** *Hospital Financial Management*, Chicago, 1975, March, vol. 29, no. 3, pp. 52-56.

This paper presents a method for determining the total financial impact of emergency medical services on the hospital. The study described involved identifying emergency room admissions (ERAs) from hospital records, and then analysing all ERA patient-related costs and charges with the aid of a computer. Information on emergency patients who were not subsequently admitted was also obtained although the study concentrated on those who were admitted. Diagrams and tables show various examples of the financial analyses made. Results showed that the bulk of financial loss generated by ERAs was due to patients in lower income groups who did not subscribe to Medicaid or a similar scheme. In-patients admitted through the emergency room generally increased financial loss to the hospital, instead of decreasing it through the payment of their hospital fees as had been expected. The study enabled the profitability of the emergency medical services to be improved, since it showed that insufficient resources were being used to register patients with the proper agencies and to collect fees due to the hospital.

1041. LILLYSTONE, D. and LESSING, D. N. **A children's emergency clinic: a review of the first year.** *Practitioner*, London, 1975, April, vol. 214, no. 1282, pp. 545-548.

General hospital casualty departments are not the ideal setting for seeing children who do not require admission, and there is often a delay before a member of the paediatric staff is available. In order to overcome these problems, the West Middlesex Hospital established an emergency clinic offering general practitioners rapid access to the paediatric staff every weekday between 1100 and 1200 hours. All children are seen first by a resident paediatric student who takes a history and examines the child. The paediatric registrar then assesses the problem and arranges investigation and

treatment. This paper reports the first year's experience. The clinic was used by 125 general practitioners who referred 425 children. The major problems were respiratory infection and abdominal pain.

1042. LOVELL, S. and others. **The functioning of a children's hospital casualty department.** *Medical Journal of Australia*, Sydney, 1975, Feb. 1, vol. i, no. 5, pp. 135-138.

Mater Misericordiae Children's Hospital is one of two major children's hospitals in Brisbane. During the week from 11 to 17 October 1972, all patients who came to the casualty department between the hours of 0730 and 2230 were recorded. Analysis showed that on weekdays most patients arrived between 0800 and 1100 hours. On Saturday and Sunday, the numbers attending were only slightly smaller than on weekdays, but were spread throughout the day. Waiting times were long in the mornings on weekdays. Thirty-six per cent of patients had otorhinolaryngological or respiratory disease and 19 per cent had trauma; only one per cent required immediate treatment. Waiting by patients is inevitable, but could be reduced by altering the duty rosters of casualty staff.

DAY HOSPITALS

See Abstract Nos. 1026, 1047

INFECTIOUS DISEASES AND ISOLATION

1043. MACGREGOR, R. R. **A year's experience with tuberculosis in a private urban teaching hospital in the postsanatorium era.** *American Journal of Medicine*, New York, 1975, Feb., vol. 58, no. 2, pp. 221-228.

The incidence of tuberculosis in the United States has declined rapidly since the introduction of chemotherapy. Consequently the focus of patient care has shifted from the special sanatorium to the general hospital, where patients usually receive an early discharge and subsequent out-patient treatment. These trends are shown in a study carried out between July 1971 and June 1972 at the Hospital of the University of Pennsylvania. Information analysed included general statistical data and information resulting from physical examination, laboratory, X-ray, culture and skin tests; these results are tabulated. The results exposed problems concerning: (i) recognition of tuberculosis in patients admitted to hospital with other diagnoses; (ii) certain aspects of management; and (iii) the transfer of patients to ambulatory care. The first problem could be overcome by effective screening of patients suspected of having tuberculosis, although 'classic' symptoms may not always be present. Physical examinations are often misleading, so a chest film is essential. Precautions are needed to ensure that patients receiving early discharge do not infect others by being allowed wide social contacts too soon. To avoid problems in transferring patients to ambulatory care, this hospital now proposes to establish its own central tuberculosis registry containing relevant information on all patients from whom *Mycobacterium tuberculosis* is isolated in the hospital.

CHILDREN

See also Abstract Nos. 987, 1026, 1041, 1042, 1057

1044. BRIMBLECOMBE, F. S. W. and others. **Bridging in health: reports of studies on health services for children, edited by Gordon McLachlan.** London, Oxford University Press, for Nuffield Provincial Hospital Trust, 1975, xii, 215pp. £2.60

Among the many challenges confronting a reorganized National Health Service is the need to continue to improve the services for children. The five papers in this volume are a contribution for all those who are embarking upon the task of making sure that the reorganized child health service provides not just a new administrative structure but a genuine advance in the well-being of all children that it will serve. The papers are on: (i) a study of paediatrics in hospital and community in Newcastle upon Tyne; (ii) the school health service and the school doctor; (iii) the report of an experimental group set up by the Humberside Area Health Authority describing their experience in establishing the constitution, role and scope of a child health care planning team; (iv) design and implementation of a developmental paediatric programme in Derbyshire; and (v) a study on congenital malformations in Devon.

1045. CROSSLEY, V. **Child life programs: an essential ingredient to good patient care.** *Hospital Administration in Canada*, Don Mills, Ont., 1975, Feb., vol. 17, no. 2, pp. 20-24.

A primary objective of virtually every paediatric setting is to provide patient care which considers physical and emotional needs together. Child life programmes are one way of achieving this objective. This paper explores why child life programmes are essential to good paediatric care and outlines some of the elements to be considered in planning them. It then goes on to discuss the qualifications of child life workers, approaches toward patients, the use of volunteers, the involvement of parents, and the personal attitudes and attributes desirable in child life workers.

GERIATRICS AND LONG-STAY

See also Abstract Nos. 928, 929, 951

1046. DEKONINCK-GAUTHIER, M.-Th. L'hôpital gériatrique est-il une nécessité dans une infrastructure hospitalière nationale? **[Is the geriatric hospital necessary in a national hospital framework?]** *Archives Belges de Médecine Sociale, Hygiène, Médecine du Travail et Médecine Legale*, Bruxelles, 1974, July, vol. 32, no. 7, pp. 401-452; summary in English, pp. 402-403.

The increasing proportion of elderly persons in the population affects many areas, especially medicine since the morbidity of this age group is particularly important. The multiple disorders of the geriatric patient will often require one or more admissions to hospital. One problem is whether to treat these patients in a general hospital or a special geriatric hospital. This paper compares these two types of hospital, weighing their respective advantages and disadvantages. It is concluded that, in the present

circumstances, the geriatric hospital is necessary. However, it is only effective if it has the necessary psychological, medical and social support both in the hospital and in the community. [This abstract has been prepared from an English summary of the paper.]

1047. FELDSCHER, B. **A walking version of ECF.** *Hospitals*, Chicago, 1975, March 1, vol. 49, no. 5, pp. 75-77, 80.

A day centre for old people has been set up in the Skilled Nursing and Intermediate Care Facility at Camden County Hospital, N.J. The minimum age is 60: incontinent patients are not accepted and those admitted must reach certain minimum mobility standards. One main meal a day is served as well as snacks. In addition to a social worker, occupational and recreational therapists and other instructors are in attendance. Workrooms give 15 sq.feet for each participant and there is a well-equipped lounge area. The daily fee is set at $1.25 but few can afford this and patients give what donations they can. Patients are transported to and from their homes, and to doctors' and shopping appointments in the centre's own transport.

CANCER

1048. PHILIP, J. F. **Relevance in oncology and its implementation in a Scottish region.** *Clinical Oncology*, London, 1975, March, vol. 1, no. 1, pp. 11-19.

A distinction is drawn between the implications of oncology organization at national level and those which are more particularly relevant to the needs of a region or area. In order to maintain viability in any regional organization there must be a nucleus of full-time staff with a clinical and an administrative commitment. The staffing pattern will vary between regions depending on the size of the area covered by the service and the particular interests of the centre itself. The form of organization developed over the last 24 years to serve the north-east of Scotland is described.

CARDIOLOGY

See also Abstract Nos. 1028, 1029

1049. GROTH, T. and others. **An off-line system for in-time analysis of cardiac catheterization data and for establishment of a cardiological database for retrospective studies.** *Computer Programs in Biomedicine*, Amsterdam, 1975, March, vol. 4, no. 3, pp. 158-174.

This paper describes a system used in clinical routine at University Hospital, Uppsala, Sweden, since January 1973. It may be divided into two major parts: (i) automatic analysis of cardiac catheterization data running off-line on a Siemens 305 computer; and (ii) storage and retrieval of the results of these analyses and additional data from related departments (thoracic surgery, internal medicine and clinical physiology) in a cardiological data base on an IBM 370/155 computer. The first part is described with special reference to: (i) operation and control during data collection, pre-processing, processing and storage of results; (ii) presentation of the results in complete and readable form; and (iii) modular design of the software. Results of a

comparison of computer and manual methods are also presented. The second part of the system is described with regard to the type of data entered in the cardiological data base.

1050. ASHCROFT, J. M. and BERRY, J. L. **The Wythenshawe Hospital patient data display system.** *European Journal of Intensive Care Medicine*, Berlin, 1975, vol. 1, no. 1, pp. 49-52.

Wythenshawe Hospital, Manchester, is a large district general hospital with over 1,000 beds and an important cardiothoracic department. This paper describes installation and implementation of a real-time patient data display system in this department and its attendant laboratories. The system consists of a Censor 908 processor with 64K bytes of core store, a two-megabyte fixed-head disc, paper tape facilities, 10 Grafoskop visual display units, 59 push-button intercoms (of which 30 can be used to input data into the system) and a hard-copy printer. To date, the system has replaced all manual records with the exception of the blood balance (not currently catered for by the system) and the drug prescription sheet. The methods used to introduce the concept to the ward staff and the manner in which they were trained in the use of the system are described.

1051. STEIN, G. and ERASEMANN, E. O. Frührehabilitation nach Herzinfarkt: institutionelle Voraussetzungen aus klinischer und sozialmedizinischer Sicht. **[Early rehabilitation following cardiac infarction: institutional prerequisites from clinical and socio-medical viewpoints.]** *Das Öffentliche Gesundheitswesen*, Stuttgart, 1975, March, vol. 37, no. 3, pp. 138-144; summary in English p. 138.

The 'Hamburg Model' for the treatment and rehabilitation of cardiac infarct patients is described: this consists of treatment and 'early mobilization' in an acute hospital (this should extend over four to eight weeks) followed by 'early rehabilitation' in a special hospital sited within 100 km. of an acute hospital. The next stage is after-care at a health resort, with the final phase in the hands of the general practitioner. There is at present a lack of suitable rehabilitation hospitals which form an essential part of the scheme. Details are given of the main requirements for a rehabilitation hospital: these include siting, equipment and staffing. The paper includes 42 references to literature.

UROLOGY

See Abstract No. 983

SURGERY

1052. MACGREGOR, A. B. and FERGUSON, J. B. P. **The organisation of surgical bed usage.** *Health Bulletin*, Edinburgh, 1975, March, vol. 33, no. 2, pp. 68-71.

Western General Hospital, Edinburgh, with a limited number of surgical beds and a waiting list of up to two years, had to accept emergency admissions on one day of each week. This caused bed occupancy problems. To alleviate this it was arranged in

the summer of 1973 for the emergency admissions to be transferred to Leith Hospital, three miles away, where there was spare bed capacity. These emergency patients were under the care of Western General Hospital staff and although medical staff time was lost in travelling between the two hospitals the system of separating emergency and elective surgery was found to have advantages as well as disadvantages. The experiment could only be run for seven weeks and this period was too short for statistical evaluation.

1053. O'DONOVAN, T. R. **The dynamics of ambulatory surgery.** *Hospital Administration*, Chicago, 1975, vol. 20, no. 1, pp. 27-39.

Out-patient surgery can free hospital beds for seriously ill patients and reduce waiting lists for elective surgery. This paper reviews the types of surgery which can be carried out effectively on an out-patient basis, and compares short-stay surgery in the hospital with independently operated out-patient surgical centres in terms of costs to patient and community, efficiency and quality of care. There is at present lively competition in the United States between the two systems; this is valuable where it improves quality and access to care without costly duplication of staff and facilities.

PLASTIC SURGERY

See Abstract No. 930

MATERNITY

See also Abstract Nos. 984, 985, 988, 991

1054. CROPLEY, C., BLOOM, R. S. and DREW, C. R. **An interaction guide for a neonatal special-care unit.** *Pediatrics*, Evanston, Ill., 1975, Feb., vol. 55, no. 2, pp. 287-290.

At the Charles R. Drew Postgraduate Medical Centre parents are able to become involved in the care of their babies who are in the neonatal special care unit. A problem arose over teaching and communicating with parents because of staff changes on the different shifts. A 'parent-staff interaction guide' has therefore been developed. The left side of the guide records phone calls, visits to the nursery and involvement in handling and caring for the infant. A blank column can be used for special procedures not common to all infants. The right side of the guide is used for noting specific information discussed with parents including spaces for medical problems, explanation of and need for different types of equipment, and discharge teaching. A separate 'progress note' sheet is kept in a folder with the guide. It is used by all disciplines for recording observations, assessments and plans related to parents. The folder is kept at the nurses' station to facilitate frequent recording and it is referred to during change of shift. The guide has been designed: (i) to co-ordinate the work of several people who deal with the child; (ii) to point out where communication with parents has been omitted; (iii) to determine the degree of parent involvement; and (iv) to aid in discharge planning and teaching. Two photographs are given which illustrate the guide.

PSYCHIATRY

See also Abstract Nos. 931, 952, 987

1055. BAROFF, G. S. **Mental retardation: nature, cause, and management.** Washington, Hemisphere Publishing Corporation, 1974, xviii, 504pp. £9.70

This book summarizes much of what is known about mentally handicapped people. It includes chapters on their care, education and employment and on hospitals and alternative forms of residential care. An extensive bibliography is included.

1056. BALTHAZAR, E. E. and STEVENS, H. A. **The emotionally disturbed, mentally retarded: a historical and contemporary perspective.** Englewood Cliffs, N.J., Prentice-Hall, 1975, xvi, 333pp. £6.60

The major theme and general purpose of this book is to present a general and yet definitive description and critique of the literature of emotional adjustment in mental retardation. It includes chapters on residential care and services and on the relationship between the institution and the community. An extensive bibliography is included.

1057. MACHETANZ, E. Personalprobleme bei der Neugründung eines Fachkrankenhauses für Jugendpsychiatrie. **[Staffing problems of the establishment of a special hospital for child psychiatry.]** *Krankenhaus*, Stuttgart, 1975, March, vol. 67, no. 3, pp. 90-97.

Construction of a psychiatric hospital for children on a 33-hectare woodland site near Haltern (North Rhine/Westphalia) began in 1968 and at present it can take 360 patients between the ages of two and 14; by 1976 it is hoped to extend the upper age limit to 18 and take 504 patients. The problems of staffing are discussed in some detail. From experience at this hospital the following conclusions are drawn: nursing staff should be recruited long before the building is ready and trained in an existing hospital of the same type; in the early stages training must be a priority (this hospital has a school for nursing assistants but qualified nurses and other paramedical staff have to train elsewhere); in addition to their routine duties all professional staff should be given opportunities to carry out special and more interesting tasks (contact with a university is useful for this); the number of patients admitted should at first be increased only gradually; it is inadvisable to lay down a standard nurse/patient ratio as conditions can vary (for the existing 360 patients the nursing staff is 179 made up of 36 qualified nurses, 95 qualified nursing assistants and 48 pupil nursing assistants: the staff/patient ratio for all staff is roughly 1:1); currently there is insufficient psychiatric training for qualified nurses but it is expected that further training leading to the grade of psychiatric nurse will be made possible. The development of a 500-bed psychiatric hospital for children may be expected to take 10 years from the initiation of planning or eight years from the start of construction: even then it will not be operating optimally.

1058. TIPPETT, J. and SMITH, B. **Developing a utilization review model for community mental health centers.** *Hospital & Community Psychiatry*, Washington, 1975, March, vol. 26, no. 3, pp. 165-166.

The Area B Community Mental Health Center, Washington, D.C., is one of four such centres that took part in Yale University's Psychiatric Utilization Review and

Evaluation Project. A multidisciplinary committee was appointed to write a plan for utilization review. Issues arising from the attempt to develop the plan included breadth of participation, comprehensiveness of review areas, problem focus using documented studies, range of information sources, implementation of studies, and feedback of findings and recommendations. It is recommended that studies should be carried out by sub-committees each of which should include at least one member of the review committee as well as representatives from various programmes and disciplines. After approval of reports by the review committee the sub-committee should provide feedback and implement any recommended action. It is felt that the model described allows maximum productivity for the time spent and could be applied in other community health centres or psychiatric facilities.

1059. HAYLER, L. S. **Administrative considerations in developing a volunteer program.** *Hospital & Community Psychiatry*, Washington, 1975, March, vol. 26, no. 3, pp. 143-145.

Volunteers have been used for more than three years in the Concord (Mass.) Mental Health Center. The Center includes an in-patient ward in a general hospital, out-patient services, a day treatment centre and nursery schools for disturbed and retarded children. Volunteers, who perform many functions, are mostly women, ranging in age from 14 to 64 years of age. Reasons for using volunteers were staff shortages and the need for services besides those provided by professionals. Volunteers have a special status and they form a useful link with the community. Requests for volunteers must be carefully screened and goals should be defined before volunteers are placed. Initially volunteers were recruited with the help of the mental health association and local schools. They are given a careful unhurried look at various jobs so that they can pick one to suit them. Suitability is gauged at an interview and it is important to understand the volunteer's motivation. All are given a brief orientation but intensive training is more useful once the volunteers are on the job. Staff need to be reminded that volunteers need continual supervision, support and the opportunity to discuss their ideas and problems. The most difficult task in starting the volunteer programme was to solicit staff support. Initially all staff had hidden resistance to the use of volunteers, but this was overcome by involving staff in the programme and making them aware of the high quality of work of volunteers.

1060. HALLAS, C. H., FRASER, W. I. and MACGILLIVRAY, R. C. **The care and training of the mentally handicapped: a manual for the caring professions. 5th edition.** Bristol, Wright, 1974, xii, 288pp. £5.00.

The fifth edition of this work, which was originally published in 1962, has a new title and two medical co-authors. These changes, as well as the revised contents, reflect the changing emphasis in the care of the mentally handicapped and the role of professions other than nursing.

1061. LEAVITT, M. **The discharge crisis: the experience of families of psychiatric patients.** *Nursing Research*, New York, 1975, Jan./Feb., vol. 24, no. 1, pp. 33-40.

The families of 16 psychiatric patients were interviewed just before discharge. In spite of wide variations in the type of family and differences in their relationships with

the hospital setting there was marked uniformity in their responses. The families were not prepared for the patients' discharge and revealed great uncertainty about the future of the patients: they did not consider that the patients were ready for discharge and they felt that they had not had a chance to express their views or take part in decision making. As a result the following recommendations are put forward: hospital staff should involve families more closely in decision making; the nurse should help the family to solve problems and plan for the future; research should be done into the learning potential and motivation of the families of psychiatric patients; and there should be a field study on the effect of family guidance and support on relapses.

1062. KATKIN, S. and others. **Using volunteer therapists to reduce hospital readmissions.** *Hospital & Community Psychiatry*, Washington, 1975, March, vol. 26, no. 3, pp. 151-153.

A multidisciplinary mental health team at Longview State Hospital, Cincinnati, Ohio, studied the problem of high recidivism in one of the state's psychiatric hospitals in 1968. Three factors which seemed to prevent effective after-care were identified: (i) vague or over-inclusive treatment goals; (ii) lack of professional manpower to provide adequate services; and (iii) failure to develop methods for evaluating programme effectiveness. Volunteers were accordingly used as therapists for former in-patients as a means of overcoming the problem. Their tasks included ensuring that patients took their medicines and kept their appointments, helping them to find housing and jobs and giving them supportive advice. A similar programme was started at the Clermont County Community Mental Health Center, Batavia, Ohio, in 1971. In the first programme the recidivism rate for 36 chronic schizophrenic women was 11 per cent for the group treated by the volunteers and 34 per cent for a control group receiving traditional care. In the second programme the rate after one year for 11 men and women with various types of schizophrenia was nine per cent for the treatment group and 37 per cent for the controls.

1063. WATSON, C. G., FULTON, J. R. and GUREL, L. **Project Anchor: a study of an unsuccessful volunteer program to help former patients.** *Hospital & Community Psychiatry*, Washington, 1975, March, vol. 26, no. 3, pp. 146-151.

Project Anchor was a volunteer programme at three United States Veterans Administration psychiatric hospitals. The volunteers or 'Anchormen' were to provide support, advice and companionship to patients on their release from hospital, help them to make use of recreational facilities and to find work and generally assist their re-integration into their home communities. A total of 171 patients were accepted for the programme, 89 for the experiment and 82 as controls. Most Anchormen were responsible for only one patient. Patients and volunteers were interviewed separately by a hospital research team 12 months after the patient's release. Follow-up questionnaires were completed by patients in both groups three and 12 months after release and readmission data from patients' files was studied by the researchers. Analysis of the data indicated that the programme had little therapeutic effect on the patients. The authors believe the results are against uncritical investment of funds and staff in out-patient volunteer programmes and that they raise serious questions about the proper role of the volunteer.

AUTHOR INDEX

Alexander, V. L. 1017
American Society of Hospital Pharmacists 1013
Ashcroft, J. M. 1050
Baer, H. 988
Baker, E. J. 954
Balthazar, E. E. 1056
Baroff, G. S. 1055
Bartzokas, C. A. 989
Baydin, L. D. 958
Bayliss, G. 972
Belkin, N. L. 1012
Bengtsson, S. 1023
Bergqvist, F. 1023
Berry, J. L. 1050
Birath, G. 1000
Björkman, A. 928, 931
Blais, N. 961
Blanjaar, J. A. 1033
Bloom, R. S. 1054
Boer, G. 956
Brenner, G. 953
Brimblecombe, F. S. W. 1044
Brock, Lord 1010
Burke, R. J. 942
Bush, P. 1038
Carlson, E. T. 1008
Catchlove, B. R. 938
Chester, T. E. 915
Clement, J.-M. 926
Cohn, R. E. 944
Collingwood, M. P. 1001
Conrad, W. F. 1014
Cook, G. K. 993
Cooke, N. J. 965
Crampton, R. S. 1028
Cropley, C. 1054
Crossley, V. 1045
Dangel, P. 991
Dekoninck-Gauthier, M.-Th. 1046
Delrue, J. 922
Denbo, R. D. 1015
Dennis, I. 1020
Derewicz, H. J. 1018
Doerr 920
Donlon, V. W. 973
Drew, C. R. 1054
Eales, J. 999
Eichhorn, S. 914
Eitzman, D. V. 988
Ellis, F. 949
Evans, A. M. 916
Farrant, E. M. 943
Favero, M. S. 983
Feldscher, B. 1047
Felton, G. 1003
Ferguson, J. B. P. 1052
Fletcher, S. 999
Floyd, G. J. 946
Foster, R. W. 962
Fraser, W. I. 1060
Freeman, J. W. 1029
Freiman, A. H. 970
Fulton, J. R. 1063
Gehibach, S. H. 984
Gibson, J. T. 1017
Gilbert, R. N. 975
Goodale, J. G. 942
Goodwin, P. 959
Goran, M. J. 1004
Gordon, B. L. 971
Grant, I. W. B. 965
Great Britain. Department of Health and Social Security 978
Great Britain. Office of Population, Censuses and Surveys. Social Survey Division 945
Grist, N. R. 986
Groth, T. 1049
Groulx, D. 961
Grün, L. 933
Gugliani, A. 1031
Gurel, L. 1063
Hallas, C. H. 1060
Hand, H. H. 957
Hayler, L. S. 1059
Henderson, S. 941
Henley, M. M. 977
Herr, C. E A. 1034
Hilliard, M. 947
Hinman, A. R. 990
Hollander, F. L. 1032
Holley, M. P. 989
Hollingsworth, 957
Holloway, D. C. 1008
Hoquet, F. 939
Hutton, P. 1011
Jeffrey, L. P. 1022
Jessee, W. F. 1005
Johansson, R. 931
Jones, C. W. 955
Karam, J. A. 1015
Katkin, S. 1062
Katz, G. 1032
Kayser, J. S. 951
Kleinherne 920
Knight, J. R. 1014
Knittle, M. A. 988
Koren, H. 982
Krasemann, E. O. 1051
Krüger, D. 934
Krugman, M. E. 1022
Lamy, P. P. 1018
Laugharne, E. 1024
Laycock, E. 963
Leavitt, M. 1061
Lefeuvre 950
Lessing, D. N. 1041
Lillystone, D. 1041
Lindahl, O. 966
Lindwall, L. 966
Longest, B. B. 968
Loughhead, M. G. 1029
Lovell, S. 1042
Lusk, E. J. 1040
Lutz-Dettinger, U. 992
Macgillivray, R. C. 1060
MacGregor, A. B. 1052
Macgregor, R. R. 1043
Machetanz, E. 1057
McKillop, W. 1006
McLachlan, G. 1044
Marks, I. 952
Mason, A. A. 1039
Means, B. J. 1018
Melchert, H. 934
Meyers, D. 1031
Mikho, E. 922
Minnigerode, F. A. 951
Moir, D. C. 1016
Monk, I. B. 996
Moore, G. T. 1002
Morse, G. P. 995
Morse, R. F. 995
Mueller, F. 980
Myers, K. G. 974
Najem, G. R. 985
Nationaal Ziekenhuisinstituut 927
National Coordinating Committee on Large Volume Parenterals 1021
Nelson, A. R. 1007
Nixson, C. 981
Novak, A. G. 1040
Nuffield Provincial Hospitals Trust 1044
O'Donovan, T. R. 1053
Parker, B. 997
Patrikas, E. O. 1034
Pfeiffer, E. A. 998
Philip, J. F. 1048
Phillips, D. F. 1036
Platou, C. N. 919
Polish Hospital Association 1027
Posch, J. 933
Ramtzén, G. 928
Rexed, B. 918
Ritterman, S. A. 997
Robinson, G. A. 960
Rochaix, M. 926
Roemer, M. I. 1030
Roux, R. G. 1040

Ruffell, D. W. 994
Sadler, J. 945
Salter, R. H. 1025
Sandlow, L. J. 1037
Scheiner, E. 970
Schnell, B. R. 1019
Sharp, C. A. 989
Shaw, A. 996
Sheldon, A. 958
Sjukvårdens och Socialvårdens Planerings- och Rationaliseringsinstitut 935, 979
Skiba, H. 936
Smejda, H. A. 964
Smith, B. 1058
Spencer, S. 938
Stein, G. 1051
Stern, W. M. 924
Stevens, H. A. 1056
Stolle, W. 987
Sunnervik, D. 929
Surand, G. 939
Tatchell, P. M. 967
Taylor, C. R. 948
Temkin, L. A. 1022
Terhaar 920
Thiede, G. 921
Thies, J. B. 969
Thompson, A. S. 925
Thompson, J. M. 1011
Thygesen, K. 917
Tippett, J. 1058
Tuson, G. 937
Vallbona, C. 1035
Vance, J. C. 1026
Walsh, D. W. 970
Wantulok, J. 966
Watson, B. W. 940
Watson, C. G. 1063
Weeber, A. J. 1033
Wegmiller, D. C. 919
Whitworth, T. 945
Wiczai, L. J. 1008

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CORRIGENDUM

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